

RECEIVED

FEB 13 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

01698

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

Montgomery Co.
County: RuralCity or town: Wash. D.C.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 yrs.

Hospital, institution, or street address where death occurred:

Glass Etc. Heights

How long in hospital or institution?

3. (a) FULL NAME

EMMA LOUISE BARRINGTON

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMAL

WHITE

WIDOWED

6. (c) Name of husband or wife

JOHN S. BARRINGTON

Oct. 8, 1862

6. (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Oct. 8, 1862

8. AGE:

83

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Brooklyn, N.Y.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

William Lewis

12. Name

London, Eng

MOTHER FATHER

13. Birthplace

EMMA CAUDER

14. Maiden name

15. Birthplace

London, Eng

16. Informant

Lewis Barrington

Address

6201-Walhonding Rd.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Oak Hill

Location

Wash. D.C.

18. Funeral director

Joseph Gowler's Sons

Address

1756-Pa. Ave NW

19. (Date rec'd by registrar)

2/9

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

01699

Reg. Dlat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

109 Quincey Street

How long in hospital or institution?

3. (a) FULL NAME

James Bigham

4. Sex 5. Color of race 6. (a) Single, married, widowed, or divorced

Male White Married

8. (b) Name of husband or wife Margaret Alicia

Bigham 8. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) October 10, 1874

8. AGE: Years Months Days If less than one day
71 4 15 hrs. min.9. Birthplace Cleveland, Tennessee
(Town, county, and state)

10. Usual occupation Retired Washington Police

11. Industry or business

FATHER 12. Name Asbury Bigham

13. Birthplace Tennessee

MOTHER 14. Maiden name Sara Carver

15. Birthplace Tennessee

16. Informant Margaret Alicia Bigham

Address 109 Quincey St., Chevy Chase, Md.

17. Burial Date thereof Feb. 27, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Nat'l Cemetery

Location Arlington, Virginia

18. Funeral director Dr. Leander G. Thompson

Address 7557 Wisconsin Blvd

19. Date rec'd by registrar 2/25/46

Wm E. Jones Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Quincey Street

(If rural, give LOCATION)

2. (a) If veteran, name war Army service 1892-1897

3. (b) Social Security Number

577-34-6809

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25, 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19, 1945 to Feb 25, 1945

and that I last saw him alive on Feb. 24, 1945

Immediate cause of death acute myocardial insufficiency
DURATION 1 mth.Due to Chronic cardio. vascular disease
2 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

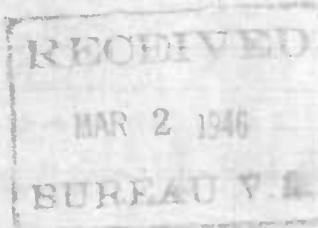
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE C. G. Bauerfield, M.D.

Address Birkdale, Md. Date signed 2/25/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(over)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 110

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

3. (a) FULL NAME

HORATIO O. BLAND

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Grace G.

7. Birth date of deceased (mo., day, yr.)

July 25th. 1878

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

67

6

17

hrs.

min.

9. Birthplace

Pelahatchie, Miss.

(Town, county, and state)

10. Usual occupation

Government Employee

11. Industry or business

Federal Public Housing

MOTHER FATHER

12. Name

William Bland

13. Birthplace

N. C.

14. Maiden name

Harriet Pettus

15. Birthplace

Alabama.

16. Informant

Mrs. Grace G. Bland

Address 8009 Eastern Ave. Silver Spring

17. Burial

Date thereof Feb. 14th. '46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery ~~XX~~ Fort Lincoln

Location

Prince Georges Co. Md.

18. Funeral director

Wm. E. Pamphrey

Address

Silver Spring, Md.

19. (Date rec'd. by registrar)

3/7 1946

Wm E. Jones

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8009 Eastern Ave.

(If rural, give LOCATION)

X

2. (a) If veteran, name war

3. (b) Social Security Number

X

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 12

1946 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 8 1946 to Feb 11 1946

and that I last saw h. m. alive on Feb 11 1946

Immediate cause of death

Cardiac failure

DURATION

1 day

Due to Hemorrhage from duodenal

ulcer

Due to Coronary Heart disease

1/2 mo.

8-7 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

operation for Rupture of duodenal

ulcer

Date of op. Dec 31 1945

Autopsy results

PHYSICIAN: Please underscore the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank G. Zack M.D.

M. D. or other

Address 112 Granville Dr Silver Spring

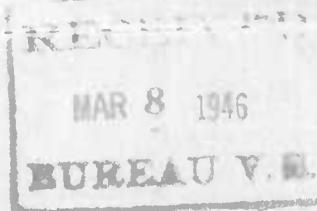
Date signed March 7 1946

Silver Spring, Md.
March 7th, 1946

This certificate replaces original CERTIFICATE
OF DEATH issued at time of death and which was lost in the
mail, between Silver Spring and Bethesda, Md. after a
Burial permit was issued at Silver Spring, Md.

The first death certificate stated July 25th, 1880
as birth date and age as 65 years; 6 months; 17 days;
That was erroneous, and is corrected hereon.

Warner E. Pumphrey
Warner E. Pumphrey
Funeral Director.



26 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *942*

01701

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:

U. S. NAVAL HOSPITAL Bethesda, Md.How long in hospital or institution? 20 days

3. (a) FULL NAME

William Henry BOLDEN, COS USN Retired, Inactive

4. Sex

5. Color or race negro 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Pearl Bolden7. Birth date of deceased (mo., day, yr.) 2-28-90 6.(c) If alive, give age years8. AGE: Years 55 Months 11 Days 23 If less than one day hrs. min.9. Birthplace Arlington, Va. (Town, county, and state)10. Usual occupation Retired11. Industry or business Naval Reserve12. Name Joseph Bolden13. Birthplace Virginia14. Maiden name Louise Holland15. Birthplace Virginia16. Informant Mrs. Pearl BoldenAddress 1238 Franklin St., NE Washington, D.C.17. Burial Burial Date thereof 3-2-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director McGuire Funeral Home *w. j. f.*Address 1820 9th St. N.W. Washington, D.C.19. 23 February 46 man Charlotte Smith
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 1238 Franklin St., N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

23 Feb. 46 11:25A20. DATE OF DEATH 23 Feb. 46 to 23 Feb. 4621. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3 Feb. 46 to 23 Feb. 46 and that I last saw him alive on 23 Feb. 46Immediate cause of death Thrombosiscoronary arteryDue to arteriosclerosis?Due to Other conditions

(Include pregnancy within 3 months of death)

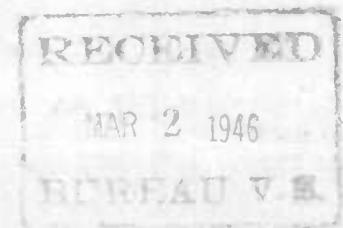
Major findings of operations Date of op. Autopsy results some or other

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE C. J. Thompson C. J. THOMPSON, Lt. Comdr. (MC) USNRM. D. or other Address USNH Bethesda, Md. Date signed 2-23-46

2/26/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5-21

01702

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

8 years

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Donald Bowie Jr

4. Sex

M.

5. Color or race

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife.....

Suzanne Bowie

7. Birth date of

deceased (mo., day, yr.)

July 22 - 1909

6. (c) If alive, give age..... years

33

8. AGE:

Years Months Days If less than one day

34

6

16

hrs. min.

9. Birthplace.....

Aspen, Montgomery Co. Md.

(Town, county, and state)

10. Usual occupation.....

Lawyer

11. Industry or business

-

MOTHER FATHER

12. Name.....

Donald Bowie Sr.

13. Birthplace

Olney, Md.

14. Maiden name.....

Annie Stenestreet

15. Birthplace

Hamden, Connecticut.

16. Informant.....

Mrs. Donald Bowie Jr.

Address

Gaithersburg, Md.

17. Burial

Date thereof..... Feb. 10, 1986

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Wesley Grove Green

Location

Woodfield Maryland

18. Funeral director

J. B. Beall Inc.

Address

Damascus, Md.

19. Date rec'd by registrar

Feb. 9 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Montgomery

City or town..... Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 #1

Woodyfield

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 21-81 1946, al

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/10/81 1945, to 21-81 1946

and that I last saw him alive on 21-81 1946

Immediate cause of death.....

Mediastinal Sarcoma 8 mo

Due to.....

Second to

Second malignancy 1 year

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

LMB

M. D. or other

Address..... Sandy St. Bldg. B

Date signed



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

01703 218
Reg. Dist. No. 218

1. PLACE OF DEATH:

County MontgomeryCity or town Rural North Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frances Virginia Bowman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

fwwidowed.6. (b) Name of husband or wife Mr. Edward Bowman

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age January 23, 1869 years

8. AGE:

Years

Months

Days

If less than one day

77 0 9 hrs. min.

9. Birthplace

Silver Run, Md.
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

own home.

FATHER

12. Name Tobias Dallas Coker

MOTHER

13. Birthplace Silver Run, Md

FATHER

14. Maiden name Aliza Frank Coker

MOTHER

15. Birthplace Silver Run, Md

FATHER

16. Informant Jessie Mabel Brown

Address

Virginia

17. Burial

(Burial, cremation, or removal, if any?) Burial Date thereof Feb 4, 46
(month) (day) (year)

Cemetery or crematory

Tenney Cemetery

Location

Silver Run, Md.

18. Funeral director

9 N Little x Son

Address

Littlestown, Pa.

19. Date rec'd by registrar

Feb 2 1946 Alfred G. Cooke

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

City or town

Silver Run

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 2 1946 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

the 20 1945 to Feb 2 1946and that I last saw him alive on Feb 2 1946

Immediate cause of death

Hemiplegia left side

DURATION

Due to

Hemorrhage of Brain

Due to

Other conditions

Varicose Veins

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

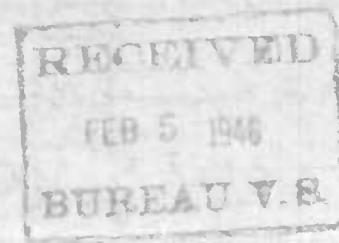
Injured at work?

23. SIGNATURE

Mary G. Sharkey, M.D.

D. or other

Address North Bethesda, Md. Date signed Feb 2, 1946



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

01704

CERTIFICATE OF DEATH

Reg. Dist. No. 213-

1. PLACE OF DEATH:

County

Montgomery

City or town

Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 months

Hospital, institution, or street address where death occurred:

205 - West Monty Ave

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Henry Bradley

7. Birth date of deceased (mo., day, yr.)

March 12 1864

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

About 81

hrs. min.

9. Birthplace

Montgomery Co - Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Orion Lumber

MOTHER FATHER

12. Name

William A. Deis

13. Birthplace

Maryland

14. Maiden name

Patricia Thomas

15. Birthplace

Maryland

16. Informant

Mr. Stephen S. Grunwell

Address

205-10 Monty Ave Rockville MD

17. Burial

Date thereof Feb 12 1946

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Rockville Union Cem.

Location

Rockville - Monty Co - Md

18. Funeral director

Tom Reuben Lumisherry

Address

Rockville - Maryland

19. Date rec'd by registrar

2/11/46 Josephine D. Mallon

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

205

West Monty Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

9 Feb

19 46, at 2A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and

19 45, to 9 Feb 19 46

and that I last saw her alive on

8 Feb 19 46

Immediate cause of death

Cerebral Hemorrhage

DURATION

10 days

Due to Arteriosclerosis

Due to

Other conditions Acute Congestive

Heart Failure

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Open

Anterior results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.S. Murphy M.D.

M. D. or other

Address

Rockville, Md

Date signed 11 Feb 46

Registrar

R

FEB 13 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *M3-B*

CERTIFICATE OF DEATH

01705
Reg. Dist. No. 223

1. PLACE OF DEATH:

County *Montgomery*City or town *Silver Spring*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Place of residence 12 yrs.*

Hospital, institution, or street address where death occurred:

*8716 Collegetown Rd*How long in hospital or institution? *Residence*

3. (a) FULL NAME

Thomas Duncan Brown

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Caucasian Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 19 1911

8. (c) If alive, give age

38 years

8. AGE:

Years <i>34</i>	Months <i>9</i>	Days <i>13</i>	If less than one day hrs. <i>0</i> min. <i>0</i>
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9. Birthplace *Boston, Mass.*

(Town, county, and state)

10. Usual occupation

Chemist

11. Industry or business

American Cleaners & Dyers Inc.

MOTHER FATHER

12. Name *James Howard Brown*

MOTHER

13. Birthplace *Jacksonville, Ill.*

FATHER

14. Maiden name *Dessau Duncan*

MOTHER

15. Birthplace *Franklin Ill.*

16. Informant

Dr. James Howard Brown (father)

Address

27 Merrymount Rd. Baltimore, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

3/2/46

(month) (day) (year)

Cemetery or crematory

Baltimore Md

Location

St. James Co

18. Funeral director

St. James Co

Address

2901-14 St 226

19. Date rec'd by registrar

Feb 2 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Montgomery*City or town *Silver Spring*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *8716 Collegetown Rd*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

438-07-9056

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 1 1946

el Tice P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

defused ear care 19. 10. 19. 19.

and that I last saw h. alive on

Immediate cause of death

Cyanide poisoning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of *3-1-46*Where did injury occur? *Silver Spring Md* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *home*

Means of injury

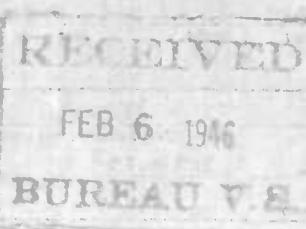
Injured at work?

23. SIGNATURE

*Frank J. Borchard M. D.*Date signed *3-1-46*

M. D. or other

Address *Bethesda Md*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466 X

01706

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mon. - 4 days

Hospital, institution, or street address where death occurred:

Suburban Hosp., Bethesda, MarylandHow long in hospital or institution? 2 mon. - 4 days

3. (a) FULL NAME

Thomas Browne4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower6. (b) Name of husband or wife ? — Deceased7. Birth date of deceased (mo., day, yr.) Oct. 25, 1873 8. (c) If alive, give age years8. AGE: Years 72 Months 3 Days 25 If less than one day hrs. 00 min. 009. Birthplace ? Ireland (Town, county, and state)10. Usual occupation minister — Retired

11. Industry or business

12. Name ? Browne13. Birthplace ? Ireland14. Maiden name ?15. Birthplace Ireland16. Informant Prob. Recs.

Address

17. Burial, cremation, or removal (Which?) Burial Date thereof 2/6/46 (month) (day) (year)Cemetery or crematory Wash. Natl. Mem. CemeteryLocation Falls Church, Va.18. Funeral director W.W. Chambers CoAddress 1400 Chapin St. N.W.19. (Date rec'd by registrar) 2/13/46 1946 John E. Jones Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Huntington (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13-46 19 1946 at 11 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 1945 to 2/13 1946 and that I last saw him alive on 2/13 1946

Immediate cause of death

starvation

DURATION

Due to carcinoma of stomach

Due to

Other conditions metastases to liver

(Include pregnancy within 3 months of death)

Major findings or operations carcinoma of stomach metastases Date of op. 2/13/46Autopsy results Carcinoma of stomach metastases loss of mucous

PHYSICIAN: Please underline the cause by which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Sophie Nowakowsky M.D. M. D. or otherAddress Suburban Hospital Date signed 2/13/46

Feb 16 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

01707

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

6 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital Bethesda, Md.

How long in hospital or institution?

6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town..... Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3616 Ordway St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

COOK, Merlyn Grail, Captain USN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	Married

6.(b) Name of husband or wife..... Mrs. Helen B. Cook

7. Birth date of deceased (mo., day, yr.)..... April 20, 1882

8. AGE: Years Months Days If less than one day
63 10 2 hrs. min.

9. Birthplace..... Ind. (Town, county, and state)

10. Usual occupation..... Navy

11. Industry or business

12. Name..... Seth A. Cook

13. Birthplace..... Ind.

14. Maiden name..... Mary McKinsey

15. Birthplace..... Ind.

16. Informant wife: Mrs. Helen B. Cook

Address..... 3616 Ordway St., N. W., Wash., D.C.

17. burial Date thereof..... 2-26-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Va.

18. Funeral director..... George W. Wise Co. J.C.F.

Address..... 2900 M St. Nth Washington, D.C.

2-22-46

19. (Date rec'd by registrar) 19.....

Mary Charlotte Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 22 Feb.

19 46 at 9:31 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

16 Feb. 19 46 to 22 Feb. 19 46

and that I last saw h. i.m. alive on 22 Feb. 19 46

Immediate cause of death..... Cerebral

Hemorrhage

Due to..... Hypertension

Cerebral arteriosclerosis

Duration..... 7 days

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

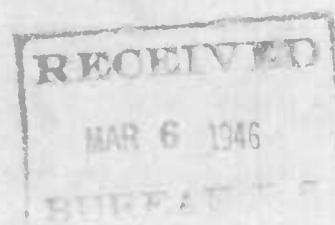
Means of Injury..... Injured at work?

23. SIGNATURE..... H. L. Jones, Jr. 1st Cond. (MC) USN

M. D. or other.....

USNH Bethesda, Md. Date signed..... 2-22-46

Address..... Date signed.....



8-148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 161-6

01708

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? admitted dead

Hospital, Institution, or street address where death occurred:
(died enroute to hospital)

How long in hospital or institution?

3. (a) FULL NAME

DAVIS, Ellen Michlen

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	Colored	

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 3, 1945

6. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
8	15		hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name	Edward William Davis
13. Birthplace	Washington, D. C.

14. Maiden name	Ellen Louise Nickons
15. Birthplace	Md.

16. Informant	father: Mr. Edward W. Davis
Address	Lincoln Park, Rockville, Md.

17. Burial	Date thereof 2-20-46
(Burial, cremation, or removal. Which?)	(month) (day) (year)

Cemetery or crematory Lincoln Park

Location Rockville, Md.

18. Funeral director Robert Snowden

Address Washington St., Rockville, Md.

19. Date rec'd by registrar 2-18 1946

Mary Charlotte Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Lincoln Park

(If rural, give LOCATION)

2. (n) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Feb. 19 46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

def med exam care 19 to 19
and that I last saw h. alive on 19.

Immediate cause of death

Cerebral edema

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations Cerebral edema

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Brookhart M.D.

2-18-46

M. D. or other

Address 2-18-46

Date signed 2-18-46

RECEIVED
FEB 25 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124-B

01769

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 Days

Hospital, institution, or street address where death occurred:

Naval Hospital Bethesda, Md.

How long in hospital or institution? 34 Days

3. (a) FULL NAME

BERARDO, DIGIACOMO V. B. P.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W*US	married

6.(b) Name of husband or wife Mrs. Anna Digiacomo

7. Birth date of deceased (mo., day, yr.) 12-18-86

8. AGE: Years	Months	Days	If less than one day
59	1	24	hrs. min.

9. Birthplace Italy

(Town, county, and state)

10. Usual occupation Watchman

11. Industry or business

12. Name Dominick Digiacomo

13. Birthplace Italy

14. Maiden name Maryanna (unknown)

15. Birthplace Italy

16. Informant Wife; Mrs. Anna Digiacomo

Address 72 Allison St. NE Wash. D.C.

17. burial Date thereof 2-15-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Virginia

18. Funeral director W. W. Chambers

Address 1400 Chapin St. NE Wash. D.C.

19. 12 Feb. 1946 19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

72 Allison St., N. E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 12 February 19 16 0340 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 January 19 16 to 12 February 19 16

and that I last saw him alive on 12 February 19 16

Immediate cause of death congestive heart failure DURATION

2 mo

Due to Pulmonary fibrosis

Due to

Other conditions cirrhosis of liver, ascites 2 yrs.
splenomegally (Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results Pulm. fibrotic cirrhosis of liver, 7/13
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

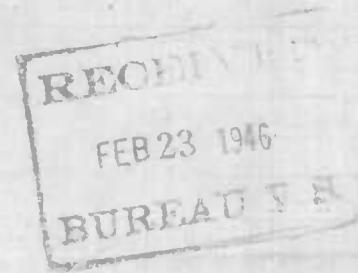
Means of injury Injured at work?

23. SIGNATURE Charles W. Thompson M. D. or other

Address U.S.N. Hosp. Bethesda Date signed 2-16-46

(Date rec'd by registrar)

Registrar





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

01710

213

Reg. Dist. No.

1. PLACE OF DEATH:

County

Montgomery

City or town

Dickerson, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life time

Hospital, institution, or street address where death occurred:

None

How long in hospital or institution?

3. (a) FULL NAME

John Edward Dorsey

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

col

married

6. (b) Name of husband or wife

Mable E. Dorsey

Dickerson, Md.

6. (c) If alive, give age

58 years

7. Birth date of

deceased (mo., day, yr.)

1894

8. AGE:

Years 57 Months

Days

If less than one day

57 1894 May 28 hrs. min.

9. Birthplace

(Martinsburg) RFD, Dickerson, Md.

(Town, county, and state)

10. Usual occupation

Sabor

11. Industry or business

Frederick N. Dorsey

12. Name

Martinsburg, Md.

MOTHER FATHER

Charlotte Hall

13. Birthplace

Martinsburg, Md.

14. Maiden name

Mable E. Dorsey

15. Birthplace

Dickerson, Md.

16. Informant

Burial

Address

Martinsburg, Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof Feb. 19, 1946

(month) (day) (year)

Cemetery or crematory

near Dickerson

Location

Clarence H. Davis

18. Funeral director

Address

Poolsville, Md.

19. Date rec'd by registrar

Feb. 19, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montg.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Rural near Dickerson

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

214-18-8562

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1946, a.m. 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sep. 1945 to 1946, to

and that I last saw h. alive on

Immediate cause of death

coronary occlusion

DURATION

dead suddenly

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Borchard, M.D.

Died Feb. 19, 1946

M.D. or other

Address Martinsburg, Md. Date signed Feb. 19, 1946

RECEIVED

FEB 21 1946

BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 776

01711

CERTIFICATE OF DEATH

Reg. Dist. No. 213-

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

February 14th 1895

8. AGE:

Years
51

Months

Days

If less than one day

hrs. min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Golden Drivr

FATHER

12. Name

Md

13. Birthplace

Harriet Ann Bouley

14. Maiden name

Md.

15. Birthplace

Ricbie Drivr

16. Informant

Deneva, Md

Address

17. Burial

Date thereof

(Burial, cremation, or removal. Which?)

Feb. 28th 1946
(month) (day) (year)

Cemetery or crematory

Deneva

Location

18. Funeral director

Robert L. Snodder

Address

246 N. Wash. St. Rockville, Md.

19. Date rec'd by registrar

Josephine D. Houston

Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Montgomery

City or town

Deneva

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 25

1946, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. med. Examiner to 19

and that I last saw h. alive on 19

Immediate cause of death

Cerebral edema

Due to

chronic alcoholism

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Brinhardt M.D.

M. D. or other

Address

Dept. of Ed. Examiner

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

01712

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

36 days

3. (a) FULL NAME

William Jerry Dyson.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MalewhiteSingle

8. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.) October 12, 1869

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

76322

hrs.

min.

9. Birthplace

Montgomery Co., Maryland

(Town, county, and state)

10. Usual occupation

—

11. Industry or business

—

MOTHER

FATHER

Benjamin DysonMaryland

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

18. Funeral director

Address

19. Date rec'd by registrar

Date thereof Feb. 6, 1946

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

Address

19. Date rec'd by registrar

19. Date rec'd by



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 320

CERTIFICATE OF DEATH

01713
Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45.

VS A15

1. PLACE OF DEATH:
County Montgomery Co., Md.City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? three mos.Hospital, Institution, or street address where death occurred: Washington SanitoriumHow long in hospital or institution? three mos.

3. (a) FULL NAME

Faulkner, Flora4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S8. (b) Name of husband or wife X7. Birth date of deceased (mo. day, yr.) Nov. 1, 1902 8. (c) If alive, give age 40 years8. AGE: Year 43 Months 3 Days 16 If less than one day hrs. 00 min. 009. Birthplace Brevard, Pennsylvania, No. Carolina
(Town, county, and state)10. Usual occupation Secretary11. Industry or business Government12. Name Williams Henry Faulkner13. Birthplace Georgia14. Maiden name Flora Harice Goodson15. Birthplace No. Carolina16. Informant Hospital RecordsAddress 17. Burial Burial Date thereof Feb. 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation Suitland, Md.18. Funeral director Jas. Faulkner SonsAddress 1756 Pa. Avenue19. Date rec'd by registrar Feb. 16, 1946 J. W. Dudley
(Date rec'd by registrar) (Registrar)2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State CountyCity or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 532-201 St. N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb. 16, 1946 at 11:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23, 1945 to Feb. 16, 1946and that I last saw her alive on Feb. 16, 1946Immediate cause of death Onset of P.R. KidneyDURATION 2 yearsDue to Due to Other conditions

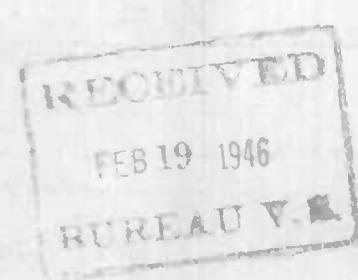
(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Robert A. Sharpe M.D. M. D. or otherAddress Takoma Park, Md. Date signed 2/16/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

01714

Reg. Dist. No. 223

1. PLACE OF DEATH:

County

Montgomery Co. Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 13 days

3. (a) FULL NAME

Mrs. Estelle Fleming

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband ~~or~~ Mr. George Fleming

7. Birth date of deceased (mo., day, yr.)

Jan. 14, 1877

8. AGE:

Years Months Days If less than one day

69

Months

Days

25 days hrs. min.

9. Birthplace

West Newton, Pa.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name ~~W. H. Anderson~~

13. Birthplace

Penna.

MOTHER

14. Maiden name Sue Hachenberry

15. Birthplace

Penna.

16. Informant

Washington Sanitarium

Address

Towson Pa. Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 11, 1946

(month) (day) (year)

Cemetery or cemetery

Centre County Memorial Park

Location

State College Pa.

18. Funeral director

Warren C. Flemings

Address

Silver Spring Md.

19. Date rec'd by registrar

February 9, 1946

(Date rec'd by registrar)

J. E. Bradley

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Penns. County Centre

City or town

State College

Street No.

439 West Pa. Ave

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1946 at 4:34 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 16 to Feb. 8, 1946

and that I last saw her alive on Feb. 8, 1946

Immediate cause of death

Coronary Occlusion

Due to Atherosclerosis (Coronary)

Due to Generalized Atherosclerosis

DURATION

2 min.

2 yrs.

2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Confirm Clinical

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert A. Ware, M.D.

M. D. or other

Address Takoma Park Md. Date signed 2/8/46

RECEIVED
FEB 13 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

01715
Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9:45:1

1. PLACE OF DEATH:

County Maryland
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 daysHospital, institution, or street address where death occurred: Washington Sanitarium and HospitalHow long in hospital or institution? 15 days

3. (a) FULL NAME

George Austin
Darby Bob Tolger4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced —6. (b) Name of husband or wife —7. Birth date of deceased (mo., day, yr.) February 25, 1946 6. (c) If alive, give age — years8. AGE: Years 1 Months — Day 1 If less than one day 18 hrs. 17 min.9. Birthplace Takoma Park, Md.
(Town, county, and state)10. Usual occupation —11. Industry or business —12. Name Arthur Francis Tolger
MOTHER FATHER13. Birthplace Massachusetts14. Maiden name Dorothy Elizabeth Boyer
MOTHER15. Birthplace Harrisburg, Pennsylvania16. Informant Washington Sanitarium RecordsAddress Takoma Park, Md.17. Date thereof Sept 28, 1946.
(Burial, cremation, or removal. Which?)Cemetery or crematory St. Nash Memorial Cemetery.Location Argyle Rd. S. Between 14th & 16th Streets, Hyattsville, Md.18. Funeral director Arthur Tolger.Address 257 Carroll St. W. Takoma Park, Md.19. Date rec'd by registrar Oct 28, 1946.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 105 West Maryland Ave.
(If rural, give LOCATION)2. (a) If veteran, name war —

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1946, at 7 a.m.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 25 Feb 1946 to 27 Feb 1946 and that I last saw him alive on 26 Feb 1946Immediate cause of death —Due to Congestive Heart Disease 48 hrs 1/2 dailyDue to —Other conditions —

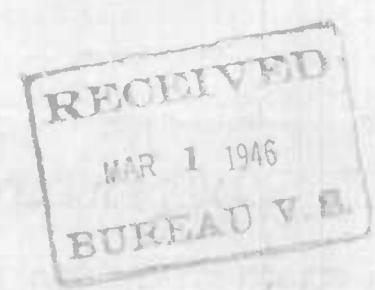
(Include pregnancy within 3 months of death)

Major findings of operations —Arteries to head arising from Pulmonary Artery burst at Party
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Marion Brown MD M. D. or other —Address — Date signed 27 Feb 46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age
of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8-2

FILM No. 100 FEB 13 1946

CERTIFICATE OF DEATH

01716

213-

Reg. Dist. No.

1. PLACE OF DEATH:

County *Montgomery*
City or town *Rockville*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 years*

Hospital, Institution, or street address where death occurred:

*727-1/4 - Moulty Ave*How long in hospital or institution? *2*

3. (a) FULL NAME

Mrs. Nellie B. Franklin

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

B. (a) Name of husband or wife

William Franklin

7. Birth date of deceased (mo., day, yr.)

October 16 - 1874

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

71 - 7 - 3 16

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Gilbert Burnet

MOTHER FATHER

12. Name

Sarah Allen

13. Birthplace

Unknown

14. Maiden name

Sarah Allen

15. Birthplace

Maryland

16. Informant

Mrs. Leilius Rosay (sister)

Address

727-1/4 - Moulty Ave Rockville

17. Burial

Rock Creek

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Rock Creek

Location

Washington D.C.

18. Funeral director

Wm. G. Burns

Address

Rockville - Maryland

19. Date rec'd by registrar

2/3/46 Josephine D. Miller

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Rockville

Street No.

727-1/4 - Moulty Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH

17 Feb 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dec 1945 to 17 Feb 1946*and that I last saw her alive on *17 Feb 1946*

Immediate cause of death

*Cerebral Hemorrhage*Due to *Arteriosclerosis*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

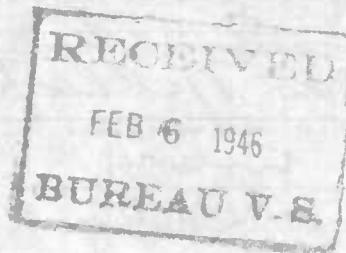
Injured at work?

23. SIGNATURE

W. S. Murphy M.D.

M. D. or other

Address *Rockville Md* Date signed *2/6/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20201

CERTIFICATE OF DEATH

01717

216

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

7216 Wisconsin Avenue, Bethesda, Md.

How long in hospital or institution?

3. (a) FULL NAME

Mr. Joseph Fricks

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Effie V. Fricks

7. Birth date of deceased (mo. day, yr.) August 13, 1884

6. (c) If alive, give age 66 years

8. AGE: Years Months Days If less than one day
61 6 13 hrs. min.9. Birthplace South Carolina
(Town, county, and state)

10. Usual occupation Restaurant business

11. Industry or business Restaurant

12. Name of James L. O. Fricks

13. Birthplace South Carolina

14. Maiden name Henrietta Tody

15. Birthplace South Carolina

16. Informant Effie V. Fricks

Address 7216 Wisconsin Ave., Bethesda, Md.

17. Burial Date thereof FEB. 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rockville Union Cemetery

Location Rockville, Maryland

18. Funeral director W. Feulner Tumprey

Address Bethesda Md

19. 2/28 1946 Wm E. Jobe

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7216 Wisconsin Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war No

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 24, 1946, to Feb. 26, 1946

and that I last saw him alive on Feb. 26, 1946.

Immediate cause of death

Cerebral hemorrhage

DURATION

2 days

Due to

Ch. arteriosclerosis

5 yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. G. Bauerfield, M.D. or other

Address Bethesda, Md. Date signed 2/26/46

RECEIVED

MAR 2 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 64

01718

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 26 hrs 15 min

3. (a) FULL NAME

Frank C. Gibson4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 27 Jan. 19378. AGE: 9 Years 0 Months 9 Days If less than one day hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation student

11. Industry or business

12. Name Raymond Gibson13. Birthplace ?14. Maiden name Ursula ?15. Birthplace ?16. Informant Raymond GibsonAddress Imvy Grove, Md17. Burial Date thereof at 8 AM 1946
(Burial, cremation, or removal. Which?)Cemetery or crematory Imvy GroveLocation Imvy Grove, Md18. Funeral director Robert L. SnowdenAddress 246-11. Wash. Rockville, Md19. Date rec'd by registrar 2-8-46 19

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 February 1946 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

4 Feb. 1946 to 5 Feb. 1946and that I last saw him alive on 5 Feb. 1946

Immediate cause of death

Stress, lymphosyphatitis

DURATION

Due to ?Due to ?Other conditions Secondary anemia

1 day

(Include pregnancy within 3 months of death)

Major findings of operations Chronically infected tonsils2. Redundant prepuce Date of op. 5 Feb. 1946

Enlarged thymus, spleen, abdominal and

Autopsy results no organic changes liver 3.0 x 2.5 blood 1.7PHYSICIAN: Please underline the cause to which death should be charged statistically 5% neck

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

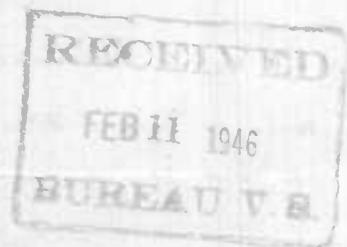
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Stuart Irons, M.D. M. D. or otherAddress Suburban Hospital Date signed 6 Feb. 1946

Registrar



PLEASE WRITE PLAINLY, WITH BLACK INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 448+

CERTIFICATE OF DEATH

Reg. Dist. No. 017216

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death..... 2 mos 12 days
Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution?..... 2 mos 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... New Jersey..... County..... Monmouth
City or town..... Long Branch
(If outside city or town limits, write RURAL and give nearest town)
Street No. 21 Locust Avenue
(If rural, give LOCATION)

3. (a) FULL NAME
GOODRIDGE, Charles Victor, S2c V6 USNR

3. (b) Social Security Number

4. Sex	5. Color or race	B.(a) Single, married, widowed, or divorced
male	white-US	Single

6. (b) Name of husband or wife.....
7. Birth date of deceased (mo., day, yr.) 16 April 1927
6. (c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day hrs. min.
18	10	6	

9. Birthplace..... Red Bank, New Jersey
(Town, county, and state)

10. Usual occupation..... U. S. Navy

11. Industry or business
MOTHER FATHER
12. Name..... Victor C. Goodridge
13. Birthplace..... Wales

MOTHER FATHER
14. Maiden name..... Ivy Stevenson
15. Birthplace..... Canada

16. Informant..... Father: Victor C. Goodridge
Address..... 21 Locust Ave., Long Branch., N.J.

17. removal
(Burial, cremation, or removal. Which?) Date thereof..... 2-23-46
(month) (day) (year)

Cemetery or crematory.....
Location..... Long Branch, N.J.

18. Funeral director..... George W. Wise Co. *J.C.F.*
Address..... 2900 M St. NW, Washington, D. C.

19. 2-23 46
(Date rec'd by registrar) Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 22 February 1946, at 6:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 1945, to 22 Feb. 1946
and that I last saw h. im. alive on 22 Feb. 1946

Immediate cause of death..... Hodgkins Sarcomatosis

DURATION

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results..... confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

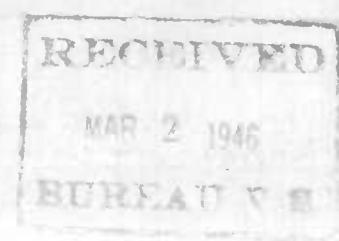
Injured at home, farm, Industry, public place (where?)

Means of injury..... Injured at work?

J. B. Shuler
J. B. Shuler, Comdr. (MC) USN

M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 2-23-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-10

01720

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 16 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 16 days

3. (a) FULL NAME

HARLING, Orindo Ray

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife Dr. Dean H. Harding

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) 2 July 1915

8. AGE: Years	Months	Days	If less than one day
30	7	16	hrs. min.

9. Birthplace Kansas

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name	Roscoe C. Ray
13. Birthplace	Ky.

14. Maiden name	Ellen Thomas
15. Birthplace	Mo.

16. Informant husband: Lt. Dean H. Harding (M.C.) USNR
Apt. 202
Address 7607 Eastern Avenue, N. W., Wash., D.C.17. Burial Date thereof 2-20-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington National
Arlington, Va.

Location

18. Funeral director Warner E. Pumphrey W.E.P.

Address 8434 Georgia Ave, Silver Spring, Md.

19. 2-18 1946 Mary Charlotte Smith
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. Md. County Mont.
Washington

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 7607 Eastern Avenue, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 18 Feb. 1946 at 5 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2 Jan 1946 to 18 Feb. 1946

and that I last saw h. alive on 18 Feb. 1946

Immediate cause of death Vascular heart disease

mitral stenosis

DURATION

3 yrs

Due to Vertebral Arteritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

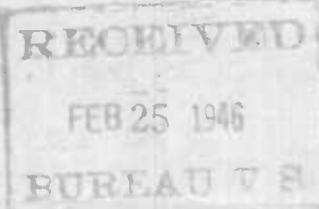
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE T. S. Barnes, Lt. Comdr. (M.C.) USNR
M. D. or other

Address USNH Bethesda, Md. Date signed 2-18-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

01722
Reg. Distr. No. 223-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH: Montgomery
County: MontgomeryCity or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred: Residence

How long in hospital or institution?.....

3. (a) FULL NAME

FREDERICK L. HARRIES4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Married6. (b) Name of husband or wife: Mrs. Alan Harries7. Birth date of deceased (mo., day, yr.): May 21, 1870 8. (c) If alive, give age: 69 years8. AGE: 75 Years 8 Months 11 Days | If less than one day: hrs. 00 min.9. Birthplace: Hanover, Wales
(Town, county, and state)10. Usual occupation: Retired Teacher11. Industry or business: Par. T. G. Schools12. Name: John L. Harries13. Birthplace: WALES14. Maiden name: JAYIES15. Birthplace: RENBY WALES10. Informant: Mrs. ADA T. HARRIESAddress: 15 Poplar Ave TAKOMA PARK17. BURIAL: BURIAL Date thereof: Feb. 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory: GLENWOOD CEMETERYLocation: WASHINGTON - D.C.18. Funeral director: Arthur HarriesAddress: 1254 George St. Takoma Park19. (Date rec'd by registrar): Feb. 2, 19462. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State: Maryland County: MontgomeryCity or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No.: 15 Poplar Ave Takoma Park
(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 1946 at 9 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to Feb. 2 1946and that I last saw him alive on Feb. 1, 1946 19.Immediate cause of death: Cerebral thrombosisDURATION: 7 daysDue to: Arteriosclerosis

20 yrs.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide:

Date of:

Where did injury occur?

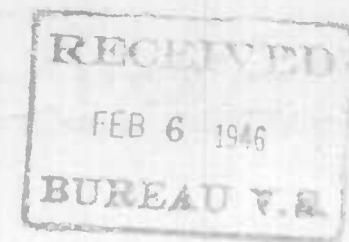
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury:

Injured at work?

23. SIGNATURE: Charles T. Carroll, M.D.M. D. or other: Charles T. Carroll, M.D.Address: 6801 - 6th St. N.W. Wash. D.C. Date signed: 2/2/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

01723

CERTIFICATE OF DEATH

Reg. Dist. No. 016.

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda, (Rural) (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 32 Days
Hospital, Institution, or street address where death occurred:..... U.S. NAVAL HOSPITAL, BETHESDA, MD.
How long in hospital or institution?..... 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... New York County.....
City or town..... Brooklyn (If outside city or town limits, write RURAL and give nearest town)
Street No. 578 57th St. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

George Joseph HART, S1c USNR

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W US	single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... November 28, 1926

8. AGE: Years	Months	Days	If less than one day
19	2	26 hrs. min.

9. Birthplace..... New York (Town, county, and state)

10. Usual occupation..... U.S. Navy

11. Industry or business.....

12. Name.....	George Hart
13. Birthplace.....	New York

14. Maiden name.....	Beckman
15. Birthplace.....	New York

18. Informant..... Mr. George Hart.

Address 578 57th St., Brooklyn, N.Y.

17. Removal (Burial, cremation, or removal. Which?)..... Date thereof..... 2-24-16
(month) (day) (year)

Cemetery or crematory.....

Location..... Brooklyn, N.Y.

18. Funeral director..... George W. Wise Co. J.C.F.

Address 2900 M St. NW Washington, D.C.

2-24 1946 Mary Charlotte Smith

19. (Date rec'd by registrar)..... 19..... Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 23 Feb. 1946 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Jan. 1946 to 23 Feb. 1946 and that I last saw him alive on 23 Feb. 1946.

Immediate cause of death.....

Bronchopneumonia off 10 days
Due to Aspiration of infected contents of Dr. lung

Due to Lung abscesses Dr. lung 10 days

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Pneumonectomy

Re Date of op.

Autopsy results..... none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

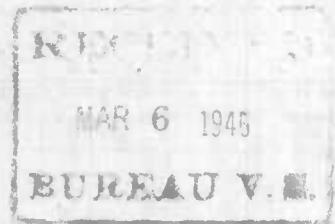
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... F. S. ASHBURN, Lt.Cdr. (MC) USN

M. D. or other

Address..... US NH Bethesda, Md. Date signed 2-24-16



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 21

CERTIFICATE OF DEATH

Reg. Dist. No. 218

01721
218

1. PLACE OF DEATH:

Montgomery Co.,
Gaithersburg Md,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yr 8 Mo.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mamie Eleanor Hart

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

Archie C Hart

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 6th 1869

8. AGE: Years Months Days If less than one day

1869 76 4 27 hrs. min.

9. Birthplace Culpepper Va.

(Town, county, and state)

10. Usual occupation House Wife

III

11. Industry or business

12. Name Thomas R Covington

13. Birthplace Va,

14. Maiden name Mary J Ashbey

15. Birthplace Va,

16. Informant Methodist Home, H. M. Wilson
Address Gaithersburg Md,17. Burial Date thereof 2/5/66
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Warrenton Cemetery

Location Warrenton Va.

18. Funeral director Ernest C Gartner
Address Gaithersburg Md,19. Date rec'd by registrar 1914 Almeda G. Cook
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md County Montg

Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3rd 46 7.45 Am 19 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 23 1946 to Feb 3 1946
and that I last saw her alive on Feb 2 1946

Immediate cause of death

Senility ratability 2-3 years

Due to Arterio-sclerosis. S. P. R.

Duration unknown.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

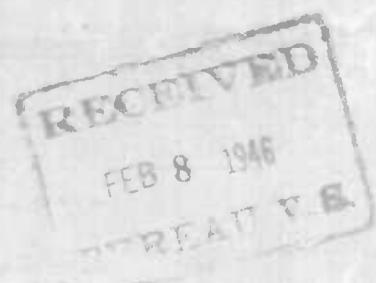
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William C. Miller M.D.
Gaithersburg, Md. M. D. or other
Address 2/3/46 Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 21724

1. PLACE OF DEATH:
County Montgomery, 9508-Biltmore Dr.
City or town Silver Spring, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Cynthia Hartsook

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife John A. Hartsook7. Birth date of deceased (mo., day, yr.) November 30, 1861

6.(c) If alive, give age years

8. AGE: Years 84 Months Days If less than one day hrs. min. 9. Birthplace Virginia
(Town, county, and state)10. Usual occupation none

11. Industry or business

FATHER 12. Name John A. Johnson
13. Birthplace Va.MOTHER 14. Maiden name unknown
15. Birthplace unknown16. Informant John W. Wilkinson
Address 605 Market St., Wilmington, Del.17. Removal-ship Date thereof 2/25/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Evergreen Cemetery
Location Roanoke, Va.18. Funeral director The S. H. Hines Co.
Address 2901-14 - at N.W. Washington D.C.19. (Date rec'd by registrar) Feb 25 1946 Josephine M. Hines, Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Md. County City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 9508-Biltmore Brive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1946 at 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 19 1946 to February 24 1946and that I last saw h. John A. Johnson alive on February 24 1946

Immediate cause of death

Cardiac dilatation DURATION 1 day

Due to

Due to

Other conditions Cardiac arrhythmia
old age (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W.M. A. Shannon

M. D. or other

Address 113 Carroll St. N.W. Date signed Feb 24 1946

RECEIVED

FEB 27 1946

BUREAU OF

CERTIFICATE OF DEATH

FILM No. 100 FEB 15 1946

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rockville, Md. 32 yrs.

Hospital, Institution, or street address where death occurred:

203 W Montg Ave

How long in hospital or institution?

3. (a) FULL NAME

Mr. John Harwood

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1869 1868

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

8. Birthplace

Buffalo N. Y.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

David Harwood

12. Name

Buffalo N. Y.

13. Birthplace

Buffalo N. Y.

14. Maiden name

Elizabeth Harwood

15. Birthplace

Buffalo N. Y.

16. Informant

Weld McKey

Address

203 W. Montg. Ave.

Cremation

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Fort Lincoln Cem

Location

Maryland - Wm Reuben Fanning

18. Funeral director

Bethesda, Maryland

Address

2/6/46 Josephine D. Shatto

Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

County

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 5

1946 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/26 1945 to 2/5 1946

and that I last saw him alive on 2/5 1946

Immediate cause of death Bronchial

pneumonia

DURATION 3 days

Due to Myocardia insufficiens

Cerebral

Due to

Other conditions arterio sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

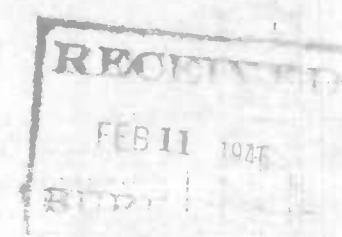
Injured at work?

23. SIGNATURE

C. E. Hawks M.D.

M. D. or other

Address Rockville Md Date signed 2/6/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 96

01726

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:

Naval Hospital Bethesda, Md.

How long in hospital or institution? 6 Days

3. (a) FULL NAME

Donald Maynard HAYENGA S/Sgt. USMC

4. Sex
male5. Color or race
W-US6.(a) Single, married, widowed, or divorced
married

6.(b) Name of husband or wife Mrs. Dorothy Hayenga

7. Birth date of
deceased (mo. day, yr.) March 10, 19218. AGE: Years 24 Months 11 Days 14 If less than one day
hrs. min.

9. Birthplace Ill. (Town, county, and state)

10. Usual occupation U.S. Marine Corp.

11. Industry or business

12. Name Evert Hayenga

13. Birthplace Ill.

14. Maiden name Helen Reints

15. Birthplace Ill.

16. Informant Mrs. Dorothy Hayenga

Address 116 4th St. Savanna, Ill.

17. removal

(Burial, cremation, or removal. Which?)

Date thereof 2-21-46

(month) (day) (year)

Cemetery or crematory Savanna

Location Savanna, Ill.

18. Funeral director Geo. W. Wise Co.

Address 2900 M St., Washington, D.C.

2-24 1946 Mary Charlotte Smith

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ill.

County

City or town Savanna

(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 4th St., Savanna, Ill.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 24 Feb.

1946 at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 Feb. 1946 to 24 Feb. 1946

and that I last saw h. alive on 24 Feb. 1946

Immediate cause of death

Respiratory failure

Due to cerebral edema

Due to pneumonia with cerebral edema

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. 2/23/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

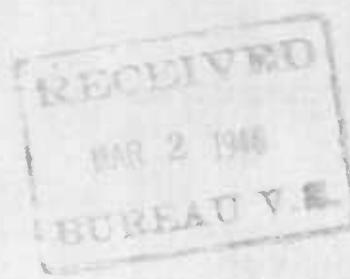
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. C. F. (MC) USNR

M. D. or other

Address USNH Bethesda, Md. Date signed 2-24-46



UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

CERTIFICATE OF DEATH

Reg. Dist. No. 223

01728

1. PLACE OF DEATH:

County

Montgomery

City or town

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

11 hours

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hosp.

How long in hospital or institution?

11 hours

3. (a) FULL NAME

Milton
Howard Baby Boy Holford

4. Sex

M

5. Color or race

white

6. (a) Single, married, widowed, or divorced

—

6. (b) Name of husband or wife

6. (c) If alive, give age

years

7. Birth date of
deceased (mo., day, yr.)

February 2, 1946

8. AGE:

Years

Months

Days

If less than one day

11 hrs.

1

min.

9. Birthplace

Takoma Park, Md.

(Town, county, and state)

10. Usual occupation

—

11. Industry or business

—

MOTHER FATHER

Paul F. Holford

MOTHER

Ethel Frances Binns

FATHER

Washington, D.C.

MOTHER

Atlantic City, N.J.

FATHER

Washington Sanitarium Records

MOTHER

Takoma Park, Md.

FATHER

Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb 4, 1946

(month) (day) (year)

Cemetery or crematory

Leyte Hash Memorial Cemetery

Location

Riggs Ave, Hyattsville, Md.

FATHER

Funeral Director

J. J. Arthur & Sons

Address 34 Carroll St, Takoma Park, Md.

FATHER

Date rec'd by registrar

Feb 3 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Prince George

City or town

Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No.

3001 Madison St. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 2, 1946, at 5:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-2-1946 to 2-2-1946

and that I last saw him alive on 2-2-1946

Immediate cause of death

Prematurity - 7 mos. preg

Due to Twin pregnancy

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Emma Hughes M.D.

M. D. or other

Address Takoma Park, Md. Date signed 2-2-46

RECEIVED
FEB 6 1946
BUREAU V-8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

01729

Reg. Dist. No. 223

1. PLACE OF DEATH:

County

Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days - 7 hours

Hospital, institution, or street address where death occurred:

Washington Suburban Hospital

How long in hospital or institution? 2 days - 7 hours

3. (a) FULL NAME

Hobart - Paul Ferguson, Jr.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Col. County

City or town Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3001 Madison St., Hyattsville, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4 1946, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-2-1946 to 2-4-1946
and that I last saw him alive on 2-2-1946

Immediate cause of death

Prematurity - Two gestations

DURATION

Due to Twin pregnancy

1946

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Emma Hughes M.D.

M. D. or other

Address Lakewood Park, Md. Date signed 2-4-46

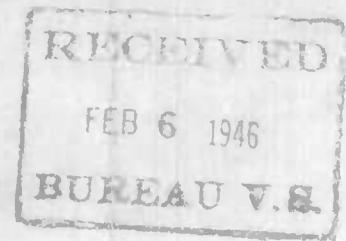
18. Funeral director

Address 254 Carroll St. Tak Park

19. Feb 5 1946 J. Wilson Dill

(Date rec'd by registrar)

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

01730

CERTIFICATE OF DEATH

Reg. Dist. No. 213-

1. PLACE OF DEATH:
 County..... Montgomery
 City or town..... Rockville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 1873
 How long in above place of death?
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... MD 1946 County..... Montgomery
 City or town..... RURAL - Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 5074-1
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Charles Washington Jackson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Married -
6.(b) Name of husband or wife..... Hester Jackson -		
7. Birth date of deceased (mo., day, yr.) 1873 Aug 22		
8. AGE: Years 72 Months 4 Days 11 If less than one day hrs. min.		
9. Birthplace..... Maryland - Montgomery County (Town, county, and state)		
10. Usual occupation..... LABORER		
11. Industry or business..... FARM -		
12. Name..... Jack Jackson		
13. Birthplace..... Maryland		
14. Maiden name..... Maria Brent		
15. Birthplace..... Maryland -		
16. Informant..... Hester Jackson, wife		
Address..... Rockville RP#2		
17. Burial..... Date thereof..... 5/5/1946 (Burial, cremation, or removal. Which?) Date thereof..... 5/5/1946 (month) (day) (year) Cemetery or crematory..... Lincoln Park		
Location..... Rockville, Md.		
18. Funeral director..... Robert L. Snawder		
Address..... Rockville, Md.		
19. Date rec'd by registrar..... 2/5/46 Josephine D. Weston		

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 2 1946 at 8:00 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 12/15/46 1946 to 2/2 1946
 and that I last saw him alive on February 1 1946

Immediate cause of death..... Congestive Heart Failure DURATION 1 month

Due to..... Congestive Heart Disease DURATION 3 years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

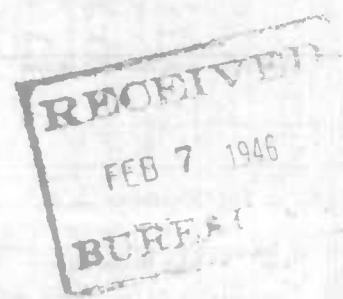
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Weller Weller
 M. D. or other
 Address..... Rockville, Md. Date signed 2/2/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

01731

CERTIFICATE OF DEATH

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

3. (a) FULL NAME

Robert Lee Johnson Jr.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>white</u>	<u>single.</u>

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 8, 19466. (c) If alive, give age years

8. AGE: Years	Months	Days	11 less than one day
			<u>8</u> hrs. <u>30</u> min.

9. Birthplace Bethesda, Montgomery County, Md.

(Town, county, and state)

10. Usual occupation Actor11. Industry or business -12. Name Robert Lee Johnson13. Birthplace Colesville, Maryland14. Maiden name Barbette Marie Poole15. Birthplace Ednor, Maryland16. Informant Hospital recordsAddress -17. Burial Burial Date thereof Feb 9 1946

(Burial, cremation, or removal? When?)

(month) (day) (year)

Cemetery or crematory Union CemeteryLocation Bethesda, Md.18. Funeral director Warren C. LumhurseyAddress Silver Spring, Md.19. Feb. 9 1946 Gertrude B. Lawyer

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)Street No. R # 2 - Calesville (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 8 1946 at 6:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1946 to February 8 1946and that I last saw him alive on February 8 1946Immediate cause of death Intestinal hemorrhageDue to Intestinal hemorrhageDue to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

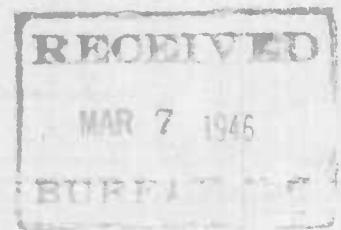
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury - Injured at work? -23. SIGNATURE JMR 3-1 M. D. or other -Address Silver Spring, Md. Date signed -



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

CERTIFICATE OF DEATH

01732

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery
City or town Germantown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William L. Jones

4. Sex

Male White Widowed
Annie Miles

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1864
(c) If alive, give age. years

8. AGE: Years 81 Months 6 Days 3 If less than one day
hrs. min.

9. Birthplace Gaithersburg, Maryland
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Charles B. Jones13. Birthplace Montgomery Co. Md.14. Maiden name Mary Elizabeth Jones15. Birthplace Montgomery Co. Md.16. Informant Mr. Grace DoreyAddress Germantown, Md.17. Buried Buried Date thereof 3/21/46

(Burial, cremation, or removal. Which) Date thereof (month) (day) (year)

Cemetery or crematory Great Oaks CemeteryLocation Gaithersburg, Md.18. Funeral director W. R. Lubben, HumphreyAddress Rockville, Md.19. Date rec'd by registrar Feb. 20 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montgomery County MontgomeryCity or town Germantown, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 19 1946 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 28 1946 to Feb. 19 1946 and that I last saw him alive on Feb. 18 1946

Immediate cause of death

Heart failure
Due to Myocardial degeneration

Central nervous system
Due to Arterio - atherosclerosis
Other conditions Irregular

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

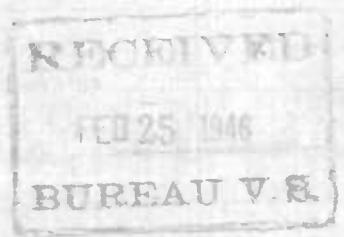
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address William C. Miller, M.D. Date signed Feb. 20 1946



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

01733

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County

Montgomery

City or town

Purdon Rural

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Sixty Years

3. (a) FULL NAME

R. Delaney King

4. Sex

Male

5. Color or race

W

B. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary S. King

7. Birth date of deceased (mo., day, yr.)

June 30 - 1874

6(c) If alive, give age 68 years

8. AGE:

71

Years

7

Months

15

Days

If less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

Farming

MOTHER FATHER

12. Name

John D. King

13. Birthplace

Maryland

14. Maiden name

Lubinda Watkins

15. Birthplace

Maryland

16. Informant

Mary S. King

Address

Montgomery Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb 17. 1946

(month) (day) (year)

Cemetery or crematory

Tannahill and

Location

Montgomery Co. Md

18. Funeral director

Roy W. Barker

Address

Tannahill and

19.

Feb. 16 1946

(Date rec'd by registrar)

Della N. Burdette

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Purdon

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 15

1946, at 6:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 10

1943

to February 15, 1946

and that I last saw him alive on February 4, 1946

Immediate cause of death

Bronchitis, Occlusion

DURATION

3 months

Due to Atherosclerotic cardio-vascular disease

10 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

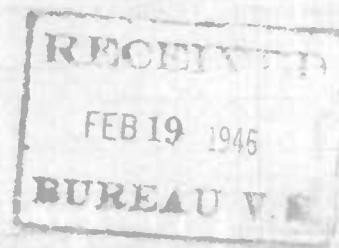
James B. Kerr M.D.

M. D. or other

Address

Montgomery, Md.

Date signed 2/16/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3D

CERTIFICATE OF DEATH

01734-216
Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45-1

VS A15

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day - 22 hrs.

Hospital, institution, or street address where death occurred:

Suburban Hospital-Bethesda, Md.How long in hospital or institution? 1 day - 22 hrs.

3. (a) FULL NAME

Mrs. Dena M. Kingsley4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1882 6. (c) If alive, give age years8. AGE: Years 63 Months 5 Days 6 If less than one day hrs. min.9. Birthplace ? Pennsylvania (Town, county, and state)10. Usual occupation Econometric Analyst11. Industry or business Dept. of Congress12. Name Geo. Kingsley13. Birthplace ?14. Maiden name Julia Reddington15. Birthplace ?

16. Informant

Address

17. Removal Date thereof 2-14-46 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director S. & H. Hines Co.Address 2901-14th St. NW.19. 2-14-46 19 (Date rec'd by registrar) ME Jones (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington (If outside city or town limits, write RURAL and give nearest town)Street No. 55 M St. N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14 1946, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11 Feb 1946 to 14 Feb 1946

and that I last saw her alive on 14 Feb 1946

Immediate cause of death coronary occlusionDURATION 3 daysDue to Hypertension cardio vascular diseaseDue to arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE D. H. Hines

M. D. or other

Address 5522 Western Ave. Date signed 2-17-46
Washington, D.C. Feb 10, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Mo.*

CERTIFICATE OF DEATH

01735

Reg. Dist. No. *217*

1. PLACE OF DEATH:

County *Montgomery*City or town *Clarksburg*, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

2 hours.

3. (a) FULL NAME

Miss Margaret Kubel

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1903

6. (c) If alive, give age years

8. AGE:

Years *43*

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name *Forrest Kubel*

13. Birthplace

Washington, D.C.

14. Maiden name

Pauline Herch

15. Birthplace

/

16. Informant

Hospital record

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof *Feb. 7, 1946*
(month) (day) (year)

Cemetery or crematory

Location *2901-14th St. N.W. Washington, D.C.*

18. Funeral director

Address *2901-14th St. N.W. Washington, D.C.*

19. Date rec'd by registrar

Date rec'd by registrar *Feb. 7, 1946*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Howard*City or town *Clarksburg*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *February 7, 1946*

at 12:24 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def. med. Exam care 19. to 19.

and that I last saw h. alive on

Immediate cause of death

Intra. cranial hemorrhage

DURATION

*3 hrs.*Due to *Fracture of base of skull (calvarial)*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *2/7/46*Where did injury occur? *Clarksburg* County *Howard* State *Md.*Injured at home, farm, industry, public place (where?) *highway*Means of injury *Auto accident*Injured at work? *No*23. SIGNATURE *Frank J. Bevans M.D.*

M. D. or other

Address *901ithersburg, Md.* Date signed *2/7/46*

RECORDED

FEB 21 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

01736

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County

Montgomery

City or town

Enon, Gaithersburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ermestine Mary Constance Lee

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Feb 21, 1946

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

5

hrs.

min.

9. Birthplace

(Town, county, and state)

Gaithersburg, Md.

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date thereof (month) (day) (year)

Brookside Cemetery, Gaithersburg, Md. P.T.O.

Gaithersburg, Md. P.T.O.

Brookside Cemetery, Gaithersburg, Md. P.T.O.

Gaithersburg, Md. P.T.O.

Feb 26, 1945 - Charles H. Sonke

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Enon, Gaithersburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

—

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 26, 1946, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 26, 1946, to Feb 26, 1946, and that I last saw her alive on Feb 25, 1946.

Immediate cause of death

Bronchitis pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

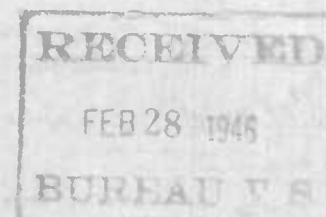
Injured at work?

23. SIGNATURE

M. D. or other

Address

Montgomery, Md. date signed Feb 26, 1946



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

01737

Reg. Dist. No. 218

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Montgomery
 City or town Emory Grove ^{MD} _{and}
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) _____

Stay in this community (yrs., or mos., or days) _____

3. (a) FULL NAME

Estine Cane Lancaster4. Sex Female 5. Color or race Single 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Feb 21 - 1846 6 (c) If alive, give age _____ years8. AGE: Years 6 Months 0 Days 3 If less than one day _____ hrs. _____ min. _____9. Birthplace At Home Montgomery County (Town, county, and state)10. Usual occupation u11. Industry or business u12. Name Bernard A Lancaster13. Birthplace Emory Grove ^{MD} _{and}14. Maiden name Mary Lee Warren15. Birthplace u16. Informant Eleanor WarrenAddress Gaithersburg ^{MD}17. Burial (Burial, cremation, or removal. Which) Burial Date thereof Feb 24 - 1946 (month) (day) (year)Cemetery or crematory Brooke Grove ^{MD}Location Montgomery Co ^{MD}18. Funeral director Roy W. BarberAddress Gaithersburg ^{MD}19. Date rec'd by registrar Feb 24 - 1946 Abdul H. Cooke Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Emory Grove ^{MD} _{and} Ward No. _____

Street No. _____

(If rural give LOCATION) u

2(a) IF VETERAN, NAME WAR _____

3. (b) Social Security Number ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1946 at 9:00 ^{AM}21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21 1946 to Feb 23 1946, and that I last saw her alive on Feb 23 1946.Immediate cause of death Bronchopneumonia

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

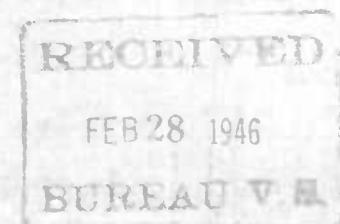
Means of injury _____

Injured at work? _____

23. SIGNATURE Oppy Shuler

M. D. or other

Address Gaithersburg Date signed 2/24/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1062

01738

CERTIFICATE OF DEATH

Reg. Dist. No. 228

1. PLACE OF DEATH: Montg Co,

County.....

City or town..... Germantown, Rural, Md.

(If outside city or town limits, write RURAL and give nearest town)

3 yrs

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Major Lee

4. Sex Male 5. Color or race Col, 6. (a) Single, married, widowed, or divorced Married

Carrie Lee

6. (b) Name of husband or wife.....

52

7. Birth date of deceased (mo., day, yr.) June 12th

8. AGE: Years 1888 Months 57 Days 24 If less than one day hrs. min.

9. Birthplace..... Maryland (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business "

12. Name..... Henry Lee

13. Birthplace..... Md,

14. Maiden name..... Amanda Warfield

15. Birthplace..... Md

16. Informant..... Carrie Lee

Address..... Germantown Md

17. Burial Date thereof..... 2/9/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Brownstown, Cemetery

Cemetery or crematory.....

Location..... Brownstown, Md,

18. Funeral director..... Ernest C Gartner

Address..... Gaithersburg Md

19. Date..... 1946

(Date rec'd by registrar) 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County..... Montg

City or town..... Germantown

Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 6th 1946 at 12.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9 ab - 2 - 1946 to Feb - 6 - 1946

and that I last saw him alive on Feb - 4 - 1946

Immediate cause of death.....

Death Heart failure 30 minutes

Due to..... Bronchitis

Due to..... Arthritis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

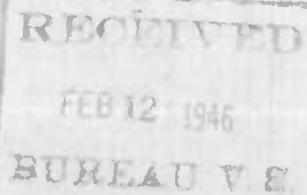
Means of injury.....

Injured at work?

23. SIGNATURE..... William B Miller M.D.

M. D. or other

Address..... Gaithersburg, Md Date signed 2/1/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4-624

CERTIFICATE OF DEATH

01739
Reg. Diat. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 98 days

3. (a) FULL NAME

Mrs Bessie Litzenberg

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

married

6. (b) Name of husband or wife Carl H. Litzenberg Jr.6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) Feb. 20 19038. AGE: Years 42 Months 11 Days 22 If less than one day hrs. min.9. Birthplace Philadelphia Penn.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Dell S. Beech13. Birthplace Philadelphia Pa.14. Maiden name Elizabeth Johnson15. Birthplace Elkton Md.16. Informant HusbandAddress 6406 Beechwood Dr. Ch. Ch. Md.17. Removed to Date thereof 2/12/46
(Burial, cremation, or removal. When?) (month) (day) (year)Cemetery or crematory Philadelphia Crematorium Crem.Location Haddadown Pa.18. Funeral director Joe Gayle's SonsAddress 1756-1a One W19. 3/11/46 1946 2pm E. J. J. J.
(Date rec'd by registrar) (Year) (Time) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cherry Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6406 Beechwood Drive

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-111946 at 4:57 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Montgomery, 15 1945 10.2-11 1946and that I last saw her alive on 19

Immediate cause of death

Cancer of lungs, liverand cancer of uterus, metastaticDue to SecondaryPrimary carcinoma of intestine.Duration two years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Cancer of uterus, lungs, liver

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sophie Nowakowsky M. D. or otherAddress Suburban Hospital Date signed 2-11-46

FFB 16 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 58-2

01740

CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A16

1. PLACE OF DEATH

County

City or town

Montgomery

Clarkesburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Rachel E. Mason

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

James H. Mason

7. Birth date of deceased (mo., day, yr.)

Sept - 10 - 1871

6. (c) If alive, give age

years

8. AGE:

Years Months Days If less than one day

74

5

3

-

hrs.

-

min.

9. Birthplace

Clarkesburg, Md.

(Town, county and state)

10. Usual occupation

house - keeping

11. Industry or business

at home

12. Name

John Henry Green

13. Birthplace

Clarkesburg, Md.

14. Maiden name

Mary Eliza Anna

15. Birthplace

Clarkesburg, Md.

16. Informant

Matilda Mason Gray

Address

Clarkesburg, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof: Feb 18-1946

(month)

(day)

(year)

Cemetery or crematory

St. John's Cemetery

Location

Montgomery Co. Md.

18. Funeral director

Bro. W. Barber

Address

Montgomery

19. Date rec'd by registrar

Feb 14 1946

Abraham H. Cooke

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For less than 6 months, give residence of mother)

State

Md.

County

Montgomery

City or town

Clarkesburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Feb. 13 - 1946 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January - 20 - 1946 to Feb. 13 - 1946

and that I last saw her alive on Feb. 13 - 1946

Immediate cause of death

Septicemia

DURATION

1 week

Due to

abcess -

1 week

Due to

bed sore

1 week

Other conditions

Inflammatory rheumatism

24 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

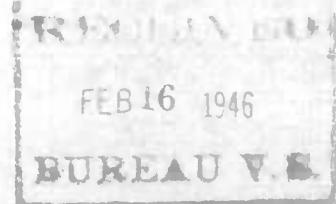
Means of injury

Injured at work?

23. SIGNATURE

William C. Miller, M.D. or other

Address: Githersburg, Md. Date signed: 27/3/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of color & sex of deceased is shown on 2411 N. Charles St., Baltimore *50*
 FILM No. 101 MAY - 2 1946 CERTIFICATE OF DEATH

01741
 14

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Montgomery
 City or town..... Silver Spring, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lily McConnell

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female <i>74</i>	White	Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

March 30, 1871

8. AGE: Years	Months	Days	If less than one day
<i>74</i>			hrs. min.

9. Birthplace..... Washington, D.C.
 (Town, county, and state)

10. Usual occupation..... At Home

11. Industry or business

12. Name.....	Abel McConnell
13. Birthplace	Unknown

14. Maiden name.....	Louisa --
15. Birthplace	Unknown

16. Informant..... Mrs. Blanche Harris
 Address Stoneleigh Courts, Wash. D.C.

17. Burial..... Date thereof..... March 1, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rock Creek Cemetery

Location..... Washington, D.C.

18. Funeral director..... The S. H. Nichols Co
 Address 2901-14 - st N.W. Wash. D.C.

19. Date rec'd by registrar..... Feb 28 1946
 Josephine Schaffner
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....	County.....
Silver Spring, Md.	(If outside city or town limits, write RURAL and give nearest town)
Street No.....	9508- Biltmore Av Drive
(If rural, give LOCATION)	

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 22 1946 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 1946 to Feb 26 1946 and that I last saw her alive on Feb 26 1946.

Immediate cause of death.....

Cardiac dilatation

DURATION

Due to..... All age, general debility

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

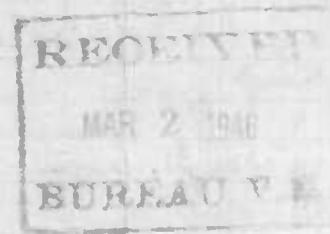
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. A. Shannon, M.D.
 M. D. or other
 Address 13 Carroll st N.W. Wash. D.C. Date signed Feb 26 1946



Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
 The correct age
 of deceased is shown on 2411 N. Charles St., Baltimore 1642
 FILM NO. I 04 MAY 28 1946 CERTIFICATE OF DEATH

01742

Reg. Dist. No. 216

1. PLACE OF DEATH

County

Montgomery

City or town

Chevy Chase, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

24 East Woodbine St.

How long in hospital or institution?

3. (a) FULL NAME

Horace Lyman McCoy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married.

8. (b) Name of husband or wife

Evelyn E.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 5, 1888

8. AGE:

57

Years

Months

Days

If less than one day

... hrs. ... min.

9. Birthplace

(Town, county, and State)

Portland, Oregon

10. Usual occupation

Director of Insurance

11. Industry or business

George McCoy

12. Name

Virginia

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Horace L. McCoy

Address

24 East Woodbine St.

17. Burial

Burial

Date thereof Feb. 6, 1946
(month) (day) (year)

(Burial, cremation, or removal, Which?)

Arlington Natl. Cem.

Cemetery or crematory

Arlington, Virginia

Location

Arlington, Virginia

18. Funeral director

John Keeber, Humphrey

Address

Bethesda, Md.

19. (Date rec'd by registrar)

2/5 1946 JHM E. Jones

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Chevy Chase, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

24 East Woodbine St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 4

1946, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Died at home 19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

Asphyxia by hanging

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 2-4-46Where did injury occur? Chevy Chase, Montgomery, Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) None

Means of injury

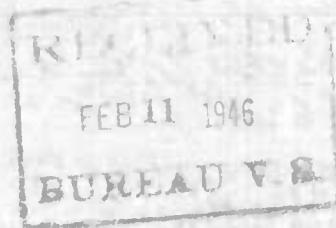
Injured at work?

23. SIGNATURE

Frank J. Borchard, M.D.

Reg. J. Exams. M. D. or other

Address Gaithersburg, Md. Date signed 2-4-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age
of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01743

FILM No. I 00 MAR 4 - 1946

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred: US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County Washington
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. 717 50th St., N.E.
(If rural, give LOCATION)

3. (a) FULL NAME

MORROW, Lewis (n)

3. (b) Social Security Number

4. Sex male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Irene Morrow

7. Birth date of deceased (mo. day, yr.) 4 April 1892
8. (c) If alive, give age years

8. AGE: Years 53 Months 10 Days 16 If less than one day hrs. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual occupation veteran

11. Industry or business

12. Name Salis Morrow

13. Birthplace S.C.

14. Maiden name Rachel Simmons

15. Birthplace N.C.

16. Informant wife: Mrs. Irene Morrow

Address 717 50th St., N.E., Wash., D.C.

17. Burial Date thereof 2-23-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director Ernest W. Jarvis

Address 1432 U St. NW Washington, D.C.

2-20 46 Mary Charlotte Smith

19. (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Feb. 1946 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Feb. 1946 to 20 Feb. 1946.

and that I last saw h. in alive on 20 Feb. 1946.

Immediate cause of death coronary thrombosis

DURATION 24h.

Due to Hypertension

Due to arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results some or none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

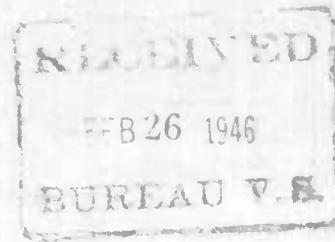
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. W. Thompson
C. W. THOMPSON, Lt. Comdr. (MC) USNR
M. D. or other

Date signed 2-20-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

01744

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH: Montg Co,
County..... Gaithersburg Md,
City or town.....
(If outside city or town limits, write RURAL and give nearest town) 70 yrs

How long in above place of death?.....
Hospital, Institution, or street address where death occurred:.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State..... Montg County.....
City or town..... Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME Henry Wooten Mulligan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	
Male	White	Married	
8.(b) Name of husband or wife..... Alice Ward Mulligan 73			
7. Birth date of deceased (mo., day, yr.)..... March 17th 1875			
8. AGE: Years	Months	Days	If less than one day
1875	70	10	24 hrs. min.
9. Birthplace..... Gaithersburg Md,			(Town, county, and state)
10. Usual occupation..... Carpenter 111			
11. Industry or business.....			
FATHER	12. Name..... Henry Mulligan	13. Birthplace..... Md	
MOTHER	14. Maiden name..... Susan Aroun	15. Birthplace..... Md	

16. Informant..... Alice Mulligan
Address..... Gaithersburg Md,
Burial..... 2/13/46

17. (Burial, cremation, or removal. Which?) Cemetery or crematory..... Forest Oak Cemetery
(month) (day) (year)..... Gaithersburg Md

Location.....

18. Funeral director..... Ernest C Gartner
Address..... Gaithersburg Md

19. Date rec'd by registrar..... 2/12/46 Address..... 2411 Charles St., Baltimore 740
Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 11 1946 at 11:56 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... to.....
and that I last saw h..... alive on.....

Immediate cause of death.....

Coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

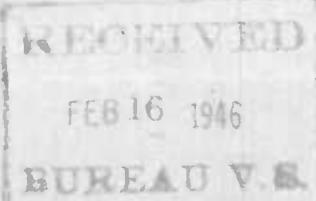
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Frank J. Brothman M.D.
Address..... 2411 Charles St., Baltimore 740
M. D. or other..... Date signed 2-11-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 232

01745

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County.....

Montgomery County

City or town.....

Gaithersburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

805 Maple Ave

How long in hospital or institution?

3. (a) FULL NAME

Alva C. Murphy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

B. (b) Name of husband or wife

Manda Murphy

7. Birth date of deceased (mo., day, yr.)

March 16th 1894

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Alabama

(Town, county and state)

10. Usual occupation

Editor

11. Industry or business

Unknown

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs. Kendall D. Phillips

Address

537 Peabody St N.W.

17. Burial

cremation

Date thereof

Feb. 25 1946
(month) (day) (year)

Cemetery or crematory

Gaithersburg Cemetery

Location

18. Funeral director

Chevy Chase Funeral Home

Address

By Ernest A. Adams 5103-Wis. Ave. N.W.

2/20/20

19. 1946

Feb. 20, 1946

Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

537 Peabody St., N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1946, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 7, 1946, to Feb. 20, 1946,

and that I last saw her alive on Feb. 19, 1946.

Immediate cause of death

Congestive heart

failure

Due to arteriosclerosis

DURATION

3 days

Due to

Other conditions

(include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. or other

Address 6911 36th St. N.W. Date signed 2/20/46

RECEIVED

FEB 22 1946

BUREAU OF

400 6700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

01746

223

Reg. Dist. No.

1. PLACE OF DEATH:

County

Montgomery

Md.

(If outside city or town limits, write RURAL and give nearest town)

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Months 4 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 7 Months 4 days

3. (a) FULL NAME

Mrs. Leanne Leckie Newmeyer

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband Edwin Jonathan

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Deceased Dec. 30 1877

8. AGE: Years 68 Months 1 Days 14 If less than one day hrs. min.

9. Birthplace Scotland

(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business None

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Washington Sanitarium & Hospital Board

Address Takoma Park, Maryland

Cremation

Date thereof 2-14-46

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director The Office co

Address 2901-14 st NW

Feb 14 1946

(Date rec'd by registrar)

19. Signature of Registrar

Handwritten Signature

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

(If outside city or town limits, write RURAL and give nearest town)

City or town Washington D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2029 Connecticut Ave., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1946 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942 1946 to Feb 14 1946

and that I last saw her alive on Feb 14 1946

Immediate cause of death Pneumonia (Hypostatic) DURATION

Due to Cerebral Hemorrhage 7 mos.

Due to Hypertension years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Adare M.D. or other

Address Takoma Park, Md. Date signed 2/14/46

55

FEB 16 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

CERTIFICATE OF DEATH

01747
2-14

Reg. Dist. No. 2-14

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

N/A street address where death occurred:

415 E. Melbourne St.

How long in hospital or institution?

3. (a) FULL NAME

EPPA R. NORRIS

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6. (b) Name of ~~wife~~ wife..... Lulu Laskey

7. Birth date of deceased (mo., day, yr.) April 16th. 1861

8. AGE: Years	Months	Days	It less than one day
84	10	5	hrs. min.

9. Birthplace..... Lancaster Co. Va.

(Town, county, and state)

10. Usual occupation..... Retired Government Employee

11. Industry or business

12. Name..... Eppa Norris

13. Birthplace..... Va.

14. Maiden name..... Elizabeth A. Livingston

15. Birthplace..... Va.

16. Informant..... Mr. Eppa L. Norris

Address..... 415 E. Melbourne St.

17. Burial..... Date thereof..... Feb. 23 - 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Glenwood

Cemetery or crematory..... Washington, D. C.

Location..... Wayne E. Lumpkin

18. Funeral director.....

Address..... 8434 Ga. Ave. Silver Spring, Md.

19. Date rec'd by registrar..... 2-22-46

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No..... 415 E. Melbourne St.

(If rural, give LOCATION)
No

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 21 1946, at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Spring 1946 to Feb. 21 1946

and that I last saw h. m. alive on Feb. 21 1946

Immediate cause of death.....

Hyperextreme heart disease

DURATION

3 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

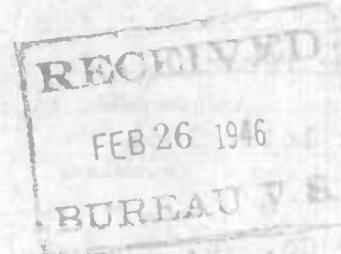
Means of injury.....

Injured at work?

23. SIGNATURE

John N. Andrew, M. D. or other

Address..... 901 Colesville Rd. Date signed..... 2-21-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-C

01748

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 14 Days

Hospital, Institution, or street address where death occurred:

Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 14 Days

3. (a) FULL NAME

OATES, Carson Clargett Mach USCGR.

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Edna Oates

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1901 8. (c) If alive, give age years

8. AGE: Years 11 Months 4 Days 14 It less than one day hrs. min.

9. Birthplace..... West Virginia (Town, county, and state)

10. Usual occupation..... U. S. Coast Guard

11. Industry or business

12. Name..... George Oates (dec.)

13. Birthplace..... Virginia

14. Maiden name..... Dollie Melon

15. Birthplace..... West Virginia

16. Informant..... Mrs. Edna Oates

Address 471 11th St. NW Washington, D.C.

17. Burial..... Cemetery or crematory..... Date thereof..... (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington, National

Location..... Arlington, Virginia

18. Funeral director..... George W. Wise J.C.F.

Address 2900 11th St. NW Washington, D.C.

19. Date of death..... 15 February 1916

(Date rec'd by registrar) Mary Charlotte Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... Washington, D.C. (If outside city or town limits, write RURAL and give nearest town)

Street No. 471 11th St. NW (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 15 February 1916 at 0340 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1916, to February 15, 1916,

and that I last saw him alive on Feb. 14, 1916.

Immediate cause of death..... compression of vital cerebral centers

Due to..... metastatic carcinoma of brain

Due to..... bronchogenic carcinoma of lungs with multiple brain metastases

Other conditions..... metastases to mediastinal lymph nodes and adrenals

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op...... Carcinomatosis, brain, lungs

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

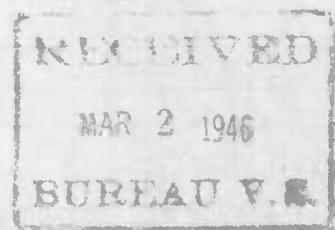
Means of injury..... Injured at work?

3. SIGNATURE..... H. C. JONES, Comdr. (MC) USNR

M. D. or other

Address..... USNH, Bethesda, Md. Date signed..... 2/15/16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

01749

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH: Montg. Co.,
County.....
Gaithersburg, Md.,
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
84 yrs
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Md. County..... Montg.
City or town..... Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Mary Elizabeth Offutt

3. (b) Social Security Number

4. Sex
Female White Widow
5. Color or race
6.(a) Single, married, widowed, or divorced

Richard Offutt
6.(b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)
Jan 17th 1862
6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
1862 84 0 24 hrs. min.

9. Birthplace..... Gaithersburg Md.,
(Town, county, and state)

10. Usual occupation..... House Wife
11. Industry or business
111

FATHER
12. Name..... John Selby
13. Birthplace..... Md.,

MOTHER
14. Maiden name..... Magarett Bowman
15. Birthplace..... Md.

16. Informant..... Walter Offutt
Address..... Gaithersburg Md.,

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof..... 2/13/46
(month) (day) (year)
Forest Oak Cemetery
Cemetery or crematory.....
Gaithersburg. Md.,
Location.....

18. Funeral director..... Ernest C. Gartner
Address..... Gaithersburg Md.,

19. Date rec'd by registrar..... Feb 12 1946
Abroda G. Cooke
Registrar
Address.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 11 1946 at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 1945, to Feb 10 1946
and that I last saw her alive on Feb 10 1946

Immediate cause of death.....
Coronary thrombosis
DURATION

Due to.....

Due to.....
High Blood Pressure

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings or operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of

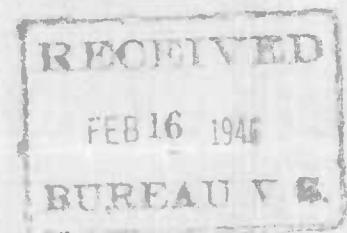
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... Mary Elizabeth Offutt
M. D. or other

Date signed..... Feb 12 1946
Address..... Gaithersburg Md.,



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

CERTIFICATE OF DEATH

01750

Reg. Dist. No. *223*

1. PLACE OF DEATH:

County

City or town

*Montgomery
Takoma Park*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

905 Prospect

How long in hospital or institution?

3. (a) FULL NAME

JOHN F. OYEMAN

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

EMMA ELIZ. OYEMAN

7. Birth date of deceased (mo., day, yr.)

SEPT. 14, 1882

(c) If alive, give age

years

8. AGE:

Years	Months	Days	It less than one day
<i>63</i>	<i>4</i>	<i>23</i>	hrs. min.

9. Birthplace

BALTIMORE CO. MD.

(Town, county and state)

10. Usual occupation

SALESMAN - REAL ESTATE

11. Industry or business

ROBERT C. OYEMAN

12. Name

ROBERT C. OYEMAN

13. Birthplace

BALTIMORE, MD.

14. Maiden name

ANNA M. GUNTRAM

15. Birthplace

BALTIMORE CO., MD.

16. Informant

EVALENA C. OYEMAN

Address

2904 EVERGREEN AVE, BALTIMORE, MD.

17. (Burial, cremation, or removal. Which?)

*CREMATION*Date thereof *Feb. 7, 1946*
(month) (day) (year)

Cemetery or crematory

Location

Baltimore

18. Funeral director

Address

247 Carroll St., Takoma Park, MD.

19. (Date rec'd by registrar)

Feb. 7, 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD*

County

City or town *Takoma Park*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *905 Prospect*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

2/7/46 at *12:00 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Oct 1945 to Feb 7, 1946*and that I last saw him alive on *2/6*Immediate cause of death *Esophageal**Esophageal**Gall Bladder & Liver*

DURATION

4 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

*Esophageal**Cancer of Liver*Date of op. *1/2/46*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

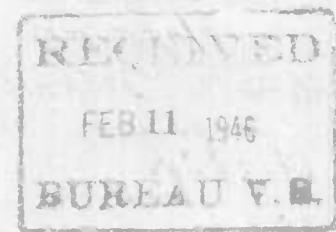
Means of injury Injured at work?

23. SIGNATURE

D. J. Daffey MD

M. D. or other

Address *4200 - 9th NW* Date signed *2/7/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

01751

223

Reg. Dist. No.

1. PLACE OF DEATH: *Montgomery Co.*
 County: *100 Baltimore Ave.,*
 City or town: *Takoma Park, Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME *Laura O'Neil Park*

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	widow

8. (b) Name of husband or wife: *Frank E. Park*7. Birth date of deceased (mo., day, yr.) *Mar 24, 1871*8. AGE: Years *74* Months Days If less than one day
 hrs. min.9. Birthplace: *Miss.*
 (Town, county, and state)10. Usual occupation: *Housewife*

11. Industry or business

12. Name: *Thomas O'Neil*13. Birthplace: *Miss.*14. Maiden name: *unknown*15. Birthplace: *unknown*16. Informant: *J. D. Park*Address: *1917 N. Troy St., Arlington, Va.*17. burial: *burial* Date thereof: *March 2, 1946*
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory: *Woodlawn Cemetery*Location: *Baltimore, Md.*18. Funeral director: *J. H. Henis & co.*Address: *2901 14th St. N.W., Wash., D.C.*19. *Feb 28 1946* (Date rec'd by registrar)2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)State: *Va.* County: *Arlington*City or town: *1917 N. Troy Street*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *1917 N. Troy Street*

(If rural, give LOCATION)

2. (a) If veteran, name war:

MEDICAL CERTIFICATION

20. DATE OF DEATH: *Feb 28 1946*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Oct 15, 1946, to Feb 28, 1946*and that I last saw her alive on *Feb 27, 1946*

Immediate cause of death:

lobar pneumonia

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: *John N. Andrews, M.D.*

M. D. or other

Address: *1218 Spring Hill* Date signed: *2-28-46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

01752

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County

Montgomery

City or town

Bethesda Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4826 North La.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Ella May Penrose

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white widowed

6. (b) Name of husband or wife

James M.

7. Birth date of deceased (mo., day, yr.)

Nov. 11, 1871

8. AGE:

Years

Months

Days

If less than one day

74

hrs.

min.

9. Birthplace

Illinois

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

John D. Clavin

12. Name

MOTHER FATHER

13. Birthplace

Ireland

14. Maiden name

Josephine Parker

15. Birthplace

New York

16. Informant

Wm Alva Penrose

Address

4826 North La. Bethesda

17. Burial, cremation, or removal (Which?)

Cremation

Date thereof

2/21/46

(month)

(day)

(year)

Cemetery or crematory

Riverside Cemetery

Location

Sterling, Illinois

18. Funeral director

Dr. Hubert Penrose

Address

7557 Wisconsin Ave. Bethesda

Md.

19. Date rec'd by registrar

2/21

1946

J. E. Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

County Maryland County Montg.

City or town Bethesda Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4826 North Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 20, 1946 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 15, 1946 to Feb. 20, 1946

and that I last saw her alive on Feb. 15, 1946

Immediate cause of death Common Thrombosis

Duration 2 days

Due to Adenocarcinotic Lung Tumor

Duration 2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

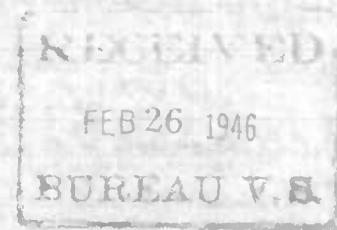
Injured at work?

23. SIGNATURE

Paul S. Sommers M. D. or other

Address 5016 Langley Rd Date signed 2/20/46

RECEIVED BY THE UNITED STATES GOVERNMENT
RECEIVED BY THE UNITED STATES GOVERNMENT



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

017532 23
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-12

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 11 days

3. (a) FULL NAME

Mrs. Katie Dairie Poole

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Females White Widowed

6. (b) Name of husband or wife

Mr. Oscar Kirk Poole

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) April 37 - 1864

8. AGE:

Years

Months

Days

If less than one day

84

9

21

hrs. min.

9. Birthplace

Goshen, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

MOTHER FATHER

12. Name

John Dairie

13. Birthplace

?

14. Maiden name

Mary Ellen Charles

?

15. Birthplace

Wm. Marvel Poole Walker

Address

Gaithersburg, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Montgomery Cemetery

Location

Bedeville, Md.

18. Funeral director

Gaffney Funeral Home

Address

Gaithersburg, Maryland

19. (Date rec'd by registrar)

Feb 18 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Gaithersburg (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 17 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 6 1946 to Feb 17 1946and that I last saw her alive on Feb 17, 1946

Immediate cause of death

terminalBroncho-pneumoniaDue to multiple lung abscessesDURATION
48 yrsDue to Chronic BronchiectasisDURATION
yesOther conditions Coronary & gen. sclerosisDURATION
yesatherosclerosis, mural thrombi, portal hypertension(Include pregnancy within 3 months of death) PyonephritisMajor findings of operations no operationDate of op. 1946Autopsy results As noted above plus rectal polyp, diverticulitis, ventral hernia.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

External causes

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

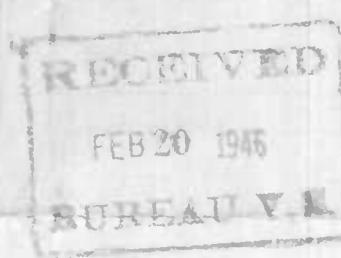
Means of injury

Injured at work?

23. SIGNATURE Read A. Colver

M. D. or other

Address Silver Spring, Md. Date signed 2-18-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

01754

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County MontgomeryCity or town Boyd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ambrose Bernard Reid

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 1 - 1868

6. (c) If alive, give age years

8. AGE:

Years 77Months 11Days 0

If less than one day

hrs. min.

9. Birthplace

Boyd, Montg Co Md

(Town, county and state)

10. Usual occupation

Retired Farmer

11. Industry or business

FATHER

12. Name Aloysius Reid

MOTHER

13. Birthplace Maryland

Maiden name

14. Maiden name Sarah Feaster

Birthplace

15. Birthplace Maryland

Informant

16. Informant Miss Eulah Reid

Address

17. Burial Boyd, Maryland

(Burial, cremation, or removal. Which?)

Date thereof 2/11/46

(month) (day) (year)

Cemetery or crematory

18. Location St. Mary's

Location

19. Funeral director Barnesville, Md

Address

20. Funeral director William B. Hilton

Address

21. Date rec'd by registrar Barnesville, Md

(Date rec'd by registrar)

22. Date signed Feb. 3 1946Signature Mrs. C.C. HiltonAddress 2211 20th St. N.W.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County MontgomeryCity or town Boyd (If outside city or town limits, write RURAL and give nearest town)Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1946

19. 46, at 2 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1910

to Jan 29 1946and that I last saw h. un alive on Jan 29 1946

19. 46

Immediate cause of death Coronary occlusionDURATION 10 minutesDue to Genl arterial sclerosis

20 yrs

Due to

Other conditions Cerebral hemorrhage

1941

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work

23. SIGNATURE

M. D. or other

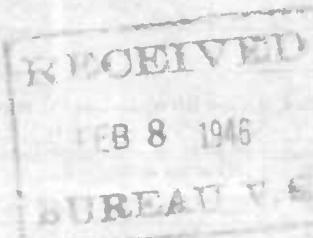
Address Upton & House, N.O.Date signed Feb. 3, 1946

LETTERS TO FRIENDS IN STATE GUATEMALA

RECORDED MAIL

MAILING 30 SEPT 1946

TELEGRAMS DIRECTED TO JAPAN



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on

2411 N. Charles St., Baltimore 945

01755

FILM No. 100 FEB 18 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: Montgomery
County.....
City or town..... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 34 days
Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hosp.
How long in hospital or institution?..... 34 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Ward
City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME Corinne
Mrs. Nova C. Reightler

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Joseph M. Reightler

7. Birth date of deceased (mo., day, yr.) March 18, 1875 6.(c) If alive, give age 71 years

8. AGE: Years 70 Months -69 Days 10 If less than one day 23 hrs. min.

9. Birthplace Union bridge, Maryland
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business Own home

MOTHER FATHER 12. Name Charles Leeds

13. Birthplace Union Bridge, Md.

14. Maiden name Belle Snyder

15. Birthplace Union Bridge, Md.

16. Informant Washington San. & Hosp. Records
& Husband

Address Takoma Park, Md.

17. Burial Burial Date thereof 2-13-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broadfording Cemetery

Location Broadfording, Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. Feb. 11 1946 J. H. H. Dodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1946 at 7:30 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 7 1946 to Feb. 10 1946 and that I last saw her alive on Feb. 10 1946

Immediate cause of death Coronary Occlusion DURATION Terminal

Due to arteriosclerosis ? years

Due to:

Other conditions Acute infective jaundice 2 days
(Include pregnancy within 3 months of death)

Major findings or operations: Date of op.

Autopsy results O PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

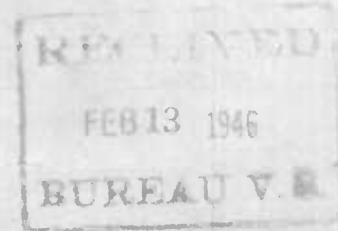
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A. Barabas M. D. or other M. D.

Address Takoma Park, Md. Date signed 2-11-46



Sh. 5055

Mr. Broome

Paterson, N.J.

Police

— Kaufman
Mr. Lee
Paterson, N.J.
Law

Spencer

Mr. ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20201

CERTIFICATE OF DEATH

Reg. Dist. No. 0175617

1. PLACE OF DEATH:

County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution?

19 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Potomac
(If outside city or town limits, write RURAL and give nearest town)

Street No. 114 Glenmont.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Richard Harlan Reynolds

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Single.

8.(b) Name of husband or wife.....

8.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) March 6, 1945

8. AGE: Years 1 Months 12 Days If less than one day hrs. min.

9. Birthplace Olney, Montgomery County, Maryland
(Town, county, and state)10. Usual occupation Artist

11. Industry or business

12. Name Robert E. Reynolds13. Birthplace Heathsville, Virginia14. Maiden name Margaret Blose15. Birthplace Summeret, Penna.16. Informant Hospital recordsAddress 1000 Carroll St., N.W. Wash. D.C.17. Burial Date thereof 2-20-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HeathsvilleLocation Heathsville, Virginia18. Funeral director Arthur WaltersAddress 254 Carroll St., N.W. Wash. D.C.19. 2-18- 1946 Gertrude B. Lawler
(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1946 at 8:12 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 17 1946 to February 18 1946 and that I last saw him alive on February 18 1946

Immediate cause of death

Brain abscess DURATION ?Due to Encephalitis DURATION ?

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

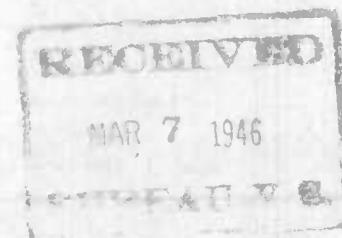
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE DR. J. M. B. Lawler M. D. February 18, 1946Address Sandy Spring, Md. Date signed 2/18/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on 2411 N. Charles St., Baltimore 4627
FILM No. 100 FEB 23 1946 CERTIFICATE OF DEATH

01757

Reg. Dist. No. 206

1. PLACE OF DEATH: Montgomery
County Bethesda
City or town. (If outside city or town limits, write RURAL and give nearest town) 2 months
How long in above place of death?
Hospital, institution, or street address where death occurred: 8200 Rockville Pike
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town. (If outside city or town limits, write RURAL and give nearest town) Bethesda
Street No. 8200 Rockville Pike
(If rural, give LOCATION)

3. (a) FULL NAME CHARLES ABRAM Ridout
4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Gladys H. Ridout
7. Birth date of deceased (mo., day, yr.) July 4, 1879 6. (c) If alive, give age 29 years
8. AGE: Years 66 Months 7 Days 11 If less than one day hrs. mto.
9. Birthplace Martinsburg, Md
(Town, county and state)
10. Usual occupation Butcher
11. Industry or business
MOTHER FATHER 12. Name JAMES Ridout
13. Birthplace Martinsburg, Md
14. Maiden name Mary 15. Birthplace Martinsburg, Md
16. Informant Gladys Ridout (wife)
Address 8200 Rockville Pike
17. Date thereof Feb 18, 1946
(Burial, cremation, or removal. Which?) Burial (month) Feb (day) 18 (year) 1946
Cemetery or crematory Martinsburg Cemetery
Location Martinsburg, Md.
18. Funeral director Snowden & Davis
Address Rockville, Md.
19. 2/18 1946 Wm E. Johnson
(Date rec'd by registrar) Registrar

2. (a) If veteran, name war.....

3. (b) Social Security Number 577-20-1835

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 15 1946 at 3 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1946 to Feb. 15, 1946
and that I last saw him alive on Feb. 14, 1946

Immediate cause of death

Carcinoma of stomach. DURATION 6 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

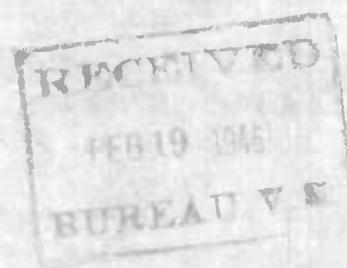
Means of injury

Injured at work?

23. SIGNATURE EG Bauerfield M.D.

M. D. or other

Address Bethesda, Md. Date signed 2/17/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County MontgomeryCity or town R.F.D. Monroe

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yearsHospital, institution, or street address where death occurred: How long in hospital or institution?

3. (a) FULL NAME

Mrs. Rosa F. Royer4. Sex FEMALE5. Color or race White6.(a) Single, married, widowed or divorced Widow6.(b) Name of husband or wife William F. Royer7. Birth date of deceased (mo., day, yr.) July 3, 18848. AGE: Years 64 Months 7 Days 5 If less than one day 9. Birthplace Rensselaer County, New York

(Town, county, and state)

10. Usual occupation None

11. Industry or business

Charles W. Hage

MOTHER FATHER

12. Name Charles W. Hage13. Birthplace New YorkEllen M. Price14. Maiden name Ellen M. Price15. Birthplace MarylandMrs. Grace Rockenhausen16. Informant Mrs. Grace Rockenhausen

Address

R.F.D. Monroe

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof February 11, 1946
(month) (day) (year)Cemetery or crematory Bethesda Cemetery

Location

Bethesda, Md.18. Funeral director Roy W. Barber

Address

Bethesda, Md.19. Feb 11 1946
(Date rec'd by registrar)Della W. Burdette

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty MontgomeryCity or town R.F.D. Monroe, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural - Near Damascus, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1946 at 2:30 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 15, 1945 to February 8, 1946and that I last saw h.e.r. alive on February 7, 1946Immediate cause of death Arteriosclerotic cardio-vascular disease DURATION 10 yearsAnd Cerebral thrombosis, right DURATION 2 yearsDue to Chronic glomerular nephritis DURATION 3 yearsOther conditions Sensitivity DURATION 3 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

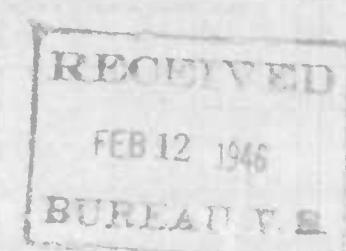
Means of injury

Injured at work?

23. SIGNATURE James D. Kerr M.D.

M. D. or other

Address Damascus, Md.Date signed 7/9/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

01759

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 93 years

Hospital, institution, or street address where death occurred:

12 Fernbrake St.

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Saely Parks Rucker

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

widowed

8. (b) Name of husband or wife

Benjamin L.

7. Birth date of deceased (mo., day, yr.)

Sept. 8, 1850

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

8. Birthplace

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

Burnell Parks

MOTHER

Virginia

13. Birthplace

Paulina Davies

14. Maiden name

Virginia

15. Birthplace

Richard O. Akers

18. Informant

7008 Hampden Ln.

17. Burial

Date thereof Feb. 6, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rockville Union Cem.

Location

Rockville, Maryland

18. Funeral director

W. Rucker Turnbrey

Address

Bethesda, Maryland

19.

2/5 1946 'pm to bed

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 4, 1946, at 2:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1930 to Feb. 4, 1946

and that I last saw her alive on Feb. 4, 1946

Immediate cause of death

Chronic Valvular Heart disease

DURATION

Due to

Due to

Other conditions Generalized arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

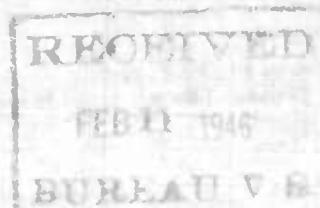
3. SIGNATURE

Silver Spring Md

M. D. or other

Date signed 2/4/46

RECEIVED TO DIRECTOR-STATE-GENERAL
FEDERAL BUREAU OF INVESTIGATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5

01760

Reg. Diet. No. 266

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... MarylandCity or town... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, institution, or street address where death occurred:

Suburban Hosp, Bethesda, MarylandHow long in hospital or institution? 22 days

3. (a) FULL NAME

Helen Virginia Siever4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced8. (b) Name of husband or wife School child

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-26-358. AGE: Years 10 Months 2 Days 18 If less than one day hrs. min.9. Birthplace Rockville, Maryland
(Town, county, and state)10. Usual occupation School child

11. Industry or business

12. Name Jess Siever13. Birthplace W. Virginia14. Maiden name Helen Whiting15. Birthplace Virginia16. Informant Jess SieverAddress Rockville Md17. Burial Date thereof Feb 16th, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Redland Lutheran Cem.Location Redland, Maryland18. Funeral director El Reubra TumpfreeAddress Bethesda Maryland19. Date rec'd by registrar 2/16 1946Signature Mrs E. Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County MarylandCity or town... Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 Bridge Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13-'46

1946 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 22 1946 to 1/13 1946

and that I last saw h. alive on 2/13 1946Immediate cause of death poliomyelitis

DURATION

Due to hysteria

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results hysteria

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

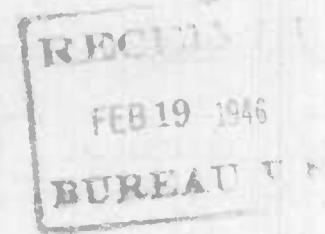
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. T. Knobbe, Jr. M. D. or otherAddress Bethesda Suburban Hosp Date signed 2/13/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

01762

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: 5 Hours

Hospital, institution, or street address where death occurred:

N.H. Bethesda, Maryland,

How long in hospital or institution: 5 Hours

3. (a) FULL NAME

STEVENS, William Shield V.B.P.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Emma L. Stevens

7. Birth date of deceased (mo., day, yr.) April 16 1876

6.(c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
69	9	29	hrs. min.

9. Birthplace: Washington, D.C.

(Town, county, and state)

10. Usual occupation: veteran

11. Industry or business

12. Name: Albert S. Stevens

13. Birthplace: Virginia

14. Maiden name: Maria Miller

15. Birthplace: Virginia

16. Informant: Mrs. Emma L. Stevens

Address: 4106 Madison St., Hyattsville, Md.

17. burial Date thereof: 2-18-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: Francis Gasch and Co.

Address: 4739 Baltimore Ave., Hyattsville, Md.

19. 15 February 1946

Mary Charlotte Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: RG

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No: 1160 Madison St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14 1946 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 14 1946 to Feb. 14 1946

and that I last saw h. alive on 14 Feb. 1946

Immediate cause of death:

Hypertensive heart disease

Due to: Persons circumstances

DURATION

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, Industry, public place (where?)

Means of injury:

Injured at work?

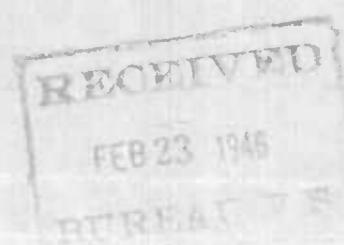
C. H. C. SMITH, Contr. (M) USNR

M. D. or other

Address: USNH Bethesda, Md.

Date signed: 2-15-46

9/20/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(112)*

CERTIFICATE OF DEATH

01761

Reg. Dist. No. 214

1. PLACE OF DEATH:

County

Montgomery

City or town

Wheaton R.R. #10 No. 1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

ANNIE AMELIA SUGRUE

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Patrick A.

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

Aug 19 - 1897

8. AGE:

48

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Montgomery Co Md

(Town, county, and state)

10. Usual occupation.

House wife

11. Industry or business

Lewis S Davidson

MOTHER FATHER

12. Name

Montgomery Co Md

13. Birthplace

Amy J. Shoemaker

14. Maiden name

Wash DC

15. Birthplace

Lester Davidson

16. Informant

Wheaton R.R. #10 No. 1

Address

Burial

Date thereof 2/23/1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Oak Hill

Location

Wash DC

18. Funeral director

The S H News Co.

Address

2901 - 14th St NW

19. Date rec'd by registrar

1946 Josephine M. Schaefer

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State 2nd

County

Montgomery

City or town Wheaton R.R. #10, 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20 1946 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-18 1946 to 2-20 1946

and that I last saw her alive on 2-20 1946

Immediate cause of death

Bronchial Asthma with
status asthmaticus

Due to Anoxia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no

Date of

Where did injury occur? no

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) no

Means of injury

no

Injured at work? no

23. SIGNATURE

Mrs. S. Puxyear

M. D. or other

Address 5005 3d Ave

Date signed 2-20-46

CO 7023



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

01763

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

Montgomery County

City or town... SILVER SPRINGS

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/2

Hospital, institution, or street address where death occurred: 1322 Dale Drive, Silver Springs

How long in hospital or institution?

3. (a) FULL NAME

CARRIE

E

TAYLOR

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

NONE

7. Birth date of deceased (mo., day, yr.)

SEPT 12, 1876

6. (c) If alive, give age years

8. AGE:

70

Years

Months

Days

Less than one day

hrs.

min.

9. Birthplace

WASHINGTON DC

(Town, county, and state)

RET. RETD

10. Usual occupation

11. Industry or business

V.

X

FATHER

12. Name... JAMES L. TAYLOR

13. Birthplace

PENN.

MOTHER

14. Maiden name... LOUISA ELLIS

15. Birthplace

PENN.

16. Informant

MRS. FANNY HURLY

Address 1516 18th Street

17. Cremation

Date thereof... 2-27-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

ROCK CREEK CEM.

Location

WASHINGTON, D.C.

18. Funeral director

J.W. GARDNER & SONS

Address

1706 Lincoln Ave NW

19. Date rec'd by registrar

1946

(Date rec'd by registrar)

Josephine McHaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD

County MONT

City or town... SILVER SPRINGS

(If outside city or town limits, write RURAL and give nearest town)

Street No... 1322 - DALE DRIVE

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

23 Feb. 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1946 to 23 Feb. 1946

and that I last saw her alive on 20 Feb. 1946

Immediate cause of death... Cardiac Failure

DURATION

Due to... Acute Pleural effusion and General Anasarca

Due to...

Other conditions... Diabetes Mellitus

4 weeks

8 years

(Include pregnancy within 8 months of death)

Major findings of operations... Multiple Thromboses of

uterus

Date of op. Jan 1946

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE

Name... Maurice A. Belanger M.D.

M. D. or other

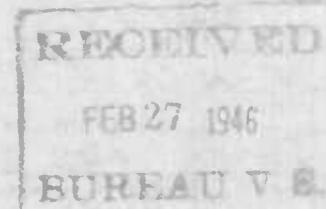
Address... 1150 Corn Ave. Date signed 2/23/46

Dr. Ellicott has been advised.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH *

2411 N. Charles St., Baltimore 3

01764

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

MRS. ANNA MARIE TELFORD

4. Sex Fem. 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife..... George C. Telford

7. Birth date of deceased (mo., day, yr.)..... Aug. 29, 1861

8. AGE: Years 84 Months 5 Days 8 It less than one day hrs. min.

9. Birthplace..... Canada (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... David Little

13. Birthplace..... Canada

14. Maiden name..... Marie Tunks

15. Birthplace..... Canada

18. Informant..... Mrs. Helen Gillions

Address..... 8618 Garfield St. Bethesda, Md.

17. Shipment..... Date thereof..... 2/9/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Emmettsburg, Iowa

Location..... Emmettsburg, Iowa

18. Funeral director..... E. J. Foy

Address..... Emmettsburg, Palo Alto Co

Iowa

19. Date record by registrar..... 2/9/46

Signature..... John E. Jones

Registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 8618 Garfield Street

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 7, 1946, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 1945 to Feb. 7, 1946

and that I last saw her alive on Feb. 7, 1946

Immediate cause of death..... Respiratory
failure

DURATION

Due to..... Carcinoma of the
bladder with metastasis

DURATION

Due to.....

Other conditions..... Arteriosclerosis

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

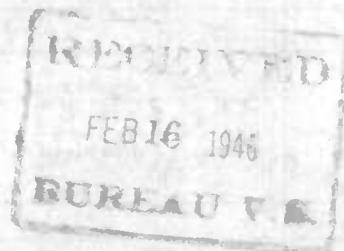
Means of injury..... Injured at work?

23. SIGNATURE..... John E. Jones

M. D. or other

Address..... 2016 Dayton Dr. Date signed..... 2/9/46

SEARCHED BY THE TEXAS STATE CRIMINAL
INVESTIGATION BUREAU
SEARCHED AND INDEXED



Evidence for addition of sex
& color is shown on

MARYLAND STATE DEPARTMENT OF HEALTH 01765

2411 N. Charles St., Baltimore 482

FILM No. 100 FEB 13 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

Washington Sanitarium Hospital

How long in hospital or institution? 5 mo. 23 days

3. (a) FULL NAME

William Christian Thompson

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced

Female White

6. (b) Name of husband or wife Clarence Thompson

7. Birth date of deceased (mo., day, yr.) Sept 25 1894 6. (c) If alive, give age years

8. AGE: Years 51 Months 4 Days 11 If less than one day hrs. 00 min.

9. Birthplace Wilmington Delaware (Town, county, and state)

10. Usual occupation Nurse

11. Industry or business

MOTHER FATHER 12. Name Joseph D. Dillman

13. Birthplace

14. Maiden name Talitha Lodge

15. Birthplace

16. Informant Sanitarium Records

Address

17. Burial Burial Date thereof Feb 8 1946 (Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory George Washington Cemetery

Location Washington, D. C.

18. Funeral director John J. Dillman

Address 27 Carroll St., Takoma Park, D. C.

19. Date rec'd by registrar Feb 6 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 805 Greenwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5. 1946 at 11:43 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to Feb 5 1946

and that I last saw her alive on Feb. 5. 1946.

Immediate cause of death

Emaciation DURATION terminal

Due to Carcinoma of Breast 3 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Robert A. Dillman Date signed Feb 13 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

01765

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

36 Hours

Hospital, institution, or street address where death occurred:

Suburban

How long in hospital or institution?

36 Hours

3. (a) FULL NAME

Sophia Regina Tichenor

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

married

6. (b) Name of husband or wife

Alfonso J. Tichenor

7. Birth date of deceased (mo. day, yr.)

March 13 1863

6. (c) If alive, give age 71 years

8. AGE: Years

Months

Days

If less than one day

82

11

34

hrs.

min.

9. Birthplace

Germany CLEVELAND, OHIO

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name UNKNOWN FRAUDIENER

13. Birthplace

14. Maiden name UNKNOWN15. Birthplace DO16. Informant ALPHONSO J. TICHENORAddress Rt. 2. Silver Spring, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof May 20 - 1946
(month) (day) (year)Cemetery or cemetery Gates of HeavenLocation East Hanover, New Jersey18. Funeral director Warren G. PumphreyAddress 8430 Ga Ave. Silver Spring, Md.19. 3/20 1946 7 M. E. Jones
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty MontgomeryCity or town Hollywood Park Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. R. F. D. #2

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 February 1946 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

27 January 1946 to 16 Feb. 1946and that I last saw her alive on 15 Feb. 1946.Immediate cause of death Cerebral hemorrhage DURATIONDue to Hypertension & Cardiovascular
Arterial disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

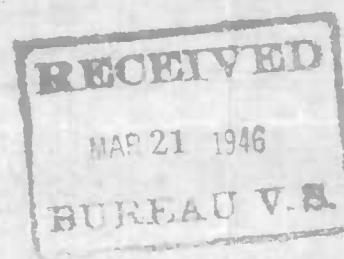
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Manning H. Alden

M. D. or other

Address 8007 Jewell Court, Silver Spring, Md. Date signed 16 Feb 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-1

01767

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

37 days

3. (a) FULL NAME

Jessie S Trumper

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife Frederick Trumper

7. Birth date of

deceased (mo., day, yr.)

Jan. 30, 1869

8. (c) If alive, give age years

8. AGE:

Years 77 Months 0 Days 18 If less than one dayhrs. min. 9. Birthplace Harmonsburg Pennsylvania

(Town, county, and state)

10. Usual occupation RETIRED PHYSICIAN

11. Industry or business

12. Name Hiram Smith13. Birthplace PENNA.14. Maiden name UNKNOWN15. Birthplace UNKNOWN16. Informant FRED J. TRUMPOURAddress 1515 SEMINARY RD. SILVER SPRING MD17. CREMATION: Date thereof FEB 18 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Crematory FORT LINCOLNLocation PRINCE GEORGES CO - MD18. Funeral director Edwines & HumphreyAddress 8434 - Ga Ave - Silver Spring MD19. (Date rec'd by registrar) 2/21 1946 Wm E. Jables
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)Street No. 1515 Seminary Road (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 FEBRUARY 1946 at 12:16 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 DECEMBER 1945 to 18 FEBRUARY 1946 and that I last saw he alive on 17 FEBRUARY 1946

Immediate cause of death

Myocardial infarction

DURATION

Due to coronary sclerosis

Due to

Arteriosclerotic kidneys

(Include pregnancy within 3 months of death)

Other conditions

Major findings of operations

Antopsy results Fibrosis of myocardium; Cancer of Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Marshall Lawrence Jr. M.D.

M. D. or other

Address 8648 Georgia Ave Date signed 18 Feb. 46
Silver Spring, MD



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-1768

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Silver Spring Hospital

How long in hospital or institution? 1 mo. 25 days

3. (a) FULL NAME

Agnes J. Vincent

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 10, 1877 8.(c) If alive, give age 79 years

8. AGE: Years 68 Months 7 Days 27 If less than one day hrs. min.

9. Birthplace France (Town, county, and state)

10. Usual occupation Retired Teacher

11. Industry or business

12. Name Henry Vincent
MOTHER FATHER

13. Birthplace France

14. Maiden name Elizabeth Crimmins
MOTHER

15. Birthplace ?

16. Informant J. F. Neelues
Address 3911 Conn. Ave. N.W. Apt. 502

17. (Burial, cremation, or removal. Which?) Burial Date thereof 2/8/46 (month) (day) (year)

Cemetery or crematory Glenwood N.J.

Location N.J.

18. Funeral director Wm Reuben Humphrey
Address Bethesda Md.

19. 2/8 1946 7pm 5 Jones
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3901 Conn Ave. N.W. Apt. 502
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1946 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12 Jan 1946 to 6 Feb 1946 and that I last saw her alive on 6 Feb 1946.

Immediate cause of death

aortic Valve Stenosis DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None Date of op.

Autopsy results Not granted

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? No (City or town) (County) (State)

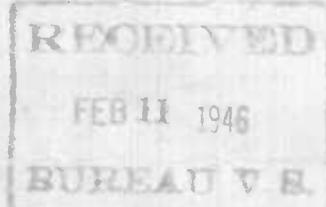
Injured at home, farm, industry, public place (where?)

Means of injury No Injured at work?

23. SIGNATURE Charles R. Haller M.D.

M. D. or other

Address 101 Eye St. N.W. Date signed 2/8/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17B

CERTIFICATE OF DEATH

01769

216

Reg. Dist. No.

1. PLACE OF DEATH:
County Montgomery

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

2 mons. 22 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 mons. 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Tenn. County
City or town Lawrenceburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 234 Hughs Street
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME
WHITE, Taylor Ostine, S1c V-6 USNR

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	W-US	married

B.(b) Name of husband or wife Della B. White

7. Birth date of deceased (mo., day, yr.) 6 January 1909

8. AGE: Years	Months	Days	If less than one day
37	1	0hrs.min.

9. Birthplace Tenn. (Town, county, and state)

10. Usual occupation Navy

11. Industry or business

FATHER	12. Name
	George Henry White

MOTHER	13. Birthplace
	Tenn.

	14. Maiden name
	Anna Lou Rhodes

	15. Birthplace
	Tenn.

16. Informant wife: Mrs. Della B. White

Address 834 Concord Avenue, N.W., Wash., D.C.

17. removal Date thereof 2-6-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Lawrenceburg, Tenn.

18. Funeral director Geo. W. Wise J.C.F.

Address 2900 M St., N.W., Wash., D.C.

19. 2-6 1946 Mary Charlotte Smith
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 F.b. 19 46 at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
14 Nov. 1945 to 6 Feb. 1946
and that I last saw her alive on 6 Feb. 1946.Immediate cause of death
Benzodiazepine pentobarbital
DURATION 4 daysDue to Perforation of Duodenum
ulcer perforating
gastroctomy (16 days) 4 daysDue to
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations and perforating +
bleeding dead ulcer Date of op.Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

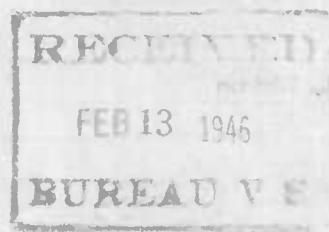
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE J.S. Ashman
M. D. or other

Address USNH Bethesda, Md. Date signed 2-6-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Distr. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Cherry Chase Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

9 East Blackthorn St.

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Violetta Strott Zies

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Emmanuel S.7. Birth date of deceased (mo., day, yr.) Oct. 29, 18828. AGE: Years 63 Months 3 Days 17 If less than one dayhrs. 0 min. 09. Birthplace Baltimore Maryland
 (Town, county, and state)10. Usual occupation Housewife11. Industry or business John Charles Strott12. Name John Charles Strott13. Birthplace Baltimore Md.14. Maiden name Mary Reiss15. Birthplace Baltimore Maryland16. Informant Emmanuel S. ZiesAddress Same as above17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 2/19/46
 (month) (day) (year)Cemetery or crematory Linden Park CemeteryLocation Baltimore Md.18. Funeral director Wm Reuben GumpfeyAddress 7557 Wisconsin Ave. Bethesda, Md.19. 3/19/46 19. 46 20. 7pm 5 p.m.

(Date rec'd by registrar) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cherry Chase Md.
 (If outside city or town limits, write RURAL and give nearest town)Street No. # 9 E. Blackthorn St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1946 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1 1946 to Feb 16 1946and that I last saw him alive on February 16 1946

Immediate cause of death

Acute Heart Failure

DURATION

10 minDue to Generalized Arteriosclerosis
Septicclerosis

2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE W. B. Gumpfey

M. D. or other

Address 943 Bonanza St. Bethesda Date signed 3/19/46

